MEDICARE VETERANS SUBVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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MEDICARE VETERANS SUBVENTION

THURSDAY, JULY 1, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:47 a.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 24, 1999
No. HL–7

CONTACT: (202) 225–3943

Thomas Announces Hearing on Medicare "Veterans Subvention"

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on proposals to allow veterans hospitals and medical clinics to receive reimbursement from Medicare for providing care to Medidcare-eligible veterans. These demonstration proposals have been referred to as "veterans subvention." The hearing will take place on Thursday, July 1, 1999, in room 1310 Longworth House Office Building, beginning at 10:30 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be limited to invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Current law generally prohibits other government agencies from receiving reimbursements for providing Medicare-covered services to Medicare-eligible beneficiaries. "Subvention" is the term given to proposals which would permit the U.S. Department of Veterans Affairs (VA) to receive reimbursement from the Medicare Trust Funds for care provided to Medicare-eligible beneficiaries at VA medical facilities.

The VA serves millions of veterans each year in 172 VA hospitals and 439 VA outpatient clinics. Many of these veterans are eligible for Medicare, and the medical care provided by the VA to these Medicare-eligible veterans is not reimbursed by Medicare. The goal of veterans subvention is to implement an alternative for delivering accessible and quality care to Medicare-eligible veterans, without increasing the cost to VA or to Medicare. In principle, Medicare-eligible military retirees who enrolled in the subvention program would get higher priority at military facilities than before, permitting them to get Medicare-covered care from VA, a new alternative to retirees' current Medicare options. Subvention could allow VA to augment appropriated funds with Medicare payments and to use excess capacity where it exists. Medicare might gain because, under veterans subvention, Medicare would pay VA less than the rate paid to private medicare providers and managed care plans.

In 1998, the U.S. House Representatives passed H.R. 4567, which included the Veterans Medicare Access Improvement Act of 1998. The Committee on Ways and Means approved similar legislation (H.R. 3828) in May 1998. Under those measures, veterans medical facilities would be permitted to receive Medicare reimbursement for health care services provided to Medicare-eligible veterans. The legislation also included a number of safeguards to ensure the Medicare Trust Funds are unharmed. A similar demonstration was established for Defense Departments facilities as part of the Balanced Budget Act of 1997 (P.L. 105–33).

In announcing the hearing, Chairman Thomas stated: "American veterans, especially those who are poor and suffer from service-connected disabilities, should have access to quality health care in return for their service to our country. Last year, we passed legislation making veterans subvention possible. This has long been a high priority for America's vets. It should be a high priority for the U.S. Congress this year as well"

FOCUS OF THE HEARING

The hearing will focus on various proposals to permit veterans' medical facilities to receive Medicare reimbursement for providing care to Medicare-eligible veterans. The Subcommittee will also consider proposals put forward by the Administration and other Members of Congress.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address and hearing date noted on a label, by the close of business, Thursday, July 15, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be IBM compatible 3.5-inch 3.5-inch diskette in WordPerfect format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways_means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including avail-

ability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The Subcommittee will come to order. It's, I guess, appropriate on the eve of the Fourth of July weekend, to have a hearing assessing the health concerns of America's veterans. So last year, the Subcommittee designed and passed legislation which would authorize veterans to receive the full continuum of Medicare services from hospitals and facilities operated by the Department of Veterans Affairs.

The key was, of course, creating greater coordination between the Veterans Administration and Medicare under the concept of subvention, here veterans subvention.

The Subcommittee's veterans subvention legislation was passed by the House as part of H.R. 4567 on October 10, 1998. However, since there was no corresponding action in the Senate before the end of the 105th, we have got to start this process all over again.

And since the House's passage of the veterans subvention bill, there have been some new developments. First, the General Accounting Office has published a study of a similar subvention program tied to a Department of Defense health care system for military retirees. And we'll hear from the GAO today about the lessons that they have learned and we may need to apply to a VA subvention.

They are not isomorphic, but they certainly have enough similarities that would require us to look carefully at the DOD subvention aspects reported by the GAO.

Second, Health Care Financing Administration and the Department of Veterans Affairs have been working together and have recently signed a memorandum of agreement, which specifies the operating details of any possible veterans subvention pilot program. However, in order for this demonstration to begin, it requires congressional action.

So we are going to hear today both from Health Care Financing Administration and the VA about how they envision veterans subvention working.

Finally, Senate Finance Committee just, I believe last week, certain recently, has taken up the issue of veterans subvention, and we look forward to working with the Finance Committee and Chairman Roth in moving legislation, since, as I said, the House acted and the Senate didn't last year.

In the past, when the Subcommittee has designed veterans subvention legislation, there have been several crucial issues that we thought ensured the success of the program.

First, was the issue of the whether the appropriate method of reimbursement is fee-for-service or some sort of capitated arrangement, and the Senate has moved in a different direction than we had in the past. And that certainly will be, and should be a subject of discussion.

Second, there is an issue of whether veterans subvention is best done at a limited number of sites or whether we have enough data to justify thinking of triggering a national program, at least for a particular profile of a veteran.

And third, the Subcommittee wants to know, how does Congress ensure that the VA continues to maintain its current level of effort for Medicare-eligible veterans, since every veteran from World War II is now Medicare eligible?

In an age of flat appropriations, with no accusations being made, we are very concerned about the limited funds of Medicare being added the Veterans Administration activities, rather than being substituted for.

And, finally, a real concern is who the veteran is, which veterans ought to be allowed access to the program. Historically, there has been a profile of veterans known as category A, which were low-income or service-related disability veterans. Category C would be other veterans.

The other concern that a number of us have is that, in looking at where the veterans hospitals have been located historically, where outpatient clinics have been built, and where veterans reside, there is a real concern about distances in terms of services that can be provided, and that the old, traditional structure simply is not adequate to many of today's veterans needs, especially Medicare-eligible veterans, given their age, and that that certainly should be part of any particular program.

And before I yield to the gentleman from California to make whatever remarks he may make, I would just like to say that I was saddened by the news story that I found in yesterday's Washington Post on the Federal page in which Dr. Kizer has decided not to run the gauntlet a second time in terms of the abuse that he would be subjected to. And frankly, it is the Veterans Administration's loss; it is the Clinton administration's loss, and it is the country's loss that someone who has been so innovative in solving veterans health care problems would be subject to such abuse. And there is clear evidence that he would have been, that his reconfirmation would have been a painful process that he was not willing to endure.

That is not in America's best interest, and in my opinion, certainly not in veterans best interests. And I just wanted to express my sympathy and concern that if good people like this aren't able to stay in government, we have got problems.

[The opening statement follows:]

Opening Statement of Hon. Bill Thomas, a Representative in Congress from the State of California

The issue of providing Medicare health benefits to America's veterans is a fitting topic for a hearing on the eve of the Fourth of July weekend. It is an issue that this Subcommittee has dealt with extensively in the past several years.

Last year, the Subcommittee designed and passed legislation which would authorize veterans to receive the full-continuum of Medicare services from hospitals and facilities operated by the Department of Veterans Affairs. Creating greater coordination between the VA and Medicare is known as "veterans subvention."

The Subcommittee's veterans subvention legislation was passed by the House, as part of H.R. 4567, on October 10, 1998. However, since there was no corresponding action in the Senate before the end of the 105th Congress, we must begin anew the legislative process this year.

Since the House's passage of the veterans subvention bill, there have been a number of developments:

First, the General Accounting Office (GAO) has published a study of a similar subvention program being operated for military retirees as part of the Defense Department's health care system. We shall hear from GAO today about lessons from that demonstration which may apply to VA subvention.

Second, the Health Care Financing Administration (HCFA) and the Department of Veterans Affairs (VA) have been working together and have recently signed a Memorandum of Agreement which specifies the operating details of any possible veterans subvention pilot program. However, in order for this demonstration to begin, Congress must act. Today, we will hear from representatives from both HCFA and the VA about how they envision veterans subvention working.

Finally, the Senate Finance Committee has recently taken up the issue and we look forward to working with Chairman Roth to move legislation this year.

In the past, when the Subcommittee has designed veterans subvention legislation, there have been several crucial issues to ensuring the success of the program:

First, there is the issue of whether the appropriate method of reimbursement is fee-for-service or some sort of capitated arrangement.

Second, there is the issue of whether veterans subvention is best done at a limited number of sites or whether we have enough to data to justify thinking in terms of a national program.

Third, the Subcommittee will want to know how does Congress ensure that the VA continues to maintain its current level of effort for Medicare-eligible veterans. In an age of flat appropriations, the VA might be tempted to shift some costs of care to the Medicare Trust Funds.

Finally—and this has always been my over-riding concern—there is the issue of which veterans should be allowed access to this new program. My own preference has always been to make low-income veterans the beneficiaries of this new program. These veterans used to be known as "Category A" veterans. In past years, the Administration has wanted to offer veterans subvention to Category C—all other veterans. I look forward to exploring the rationale for the Administration's position.

Chairman THOMAS. I yield to the gentleman from California.

Mr. STARK. Well, thank you, Mr. Chairman. I gather this is largely a repeat of last year's effort, and I would just say as I did last year, those of us veterans who support the effort for veterans, think about Bataan, Iwo Jima, I think Dr. McDermott was probably in both of those battles, but it is interesting that the Majority, that the Republicans, are mixed up as they usually are.

Here we are——

Chairman THOMAS. Why is that?

Mr. STARK. Well, just because it is strange, here we are supporting a system that is pure socialism, government medicine, socialized medicine, for those of us who fought to keep this country safe from communism. Now, we have free-market choices for Medicaid beneficiaries and for the poor, we have free-market choices for immigrants who never fought to protect our country, and here we are subjecting our veterans to socialism. I just don't understand it.

Now, I do think the VA and the Department of Defense hospitals do a pretty good job, but—and I wish that America's 43 million uninsured could be subject to the same degree of socialism that we subject our veterans to.

But, in a more serious vein, the subvention bill has raised some questions the Chairman mentioned, quality, for these veterans. The payments will be less than what we pay the private sector Medicare HMOs. So maybe the quality can't be as good.

Maybe we should just contract all this out, and maybe that would save money. According to the Breaux-Thomas bill, we will save a lot of money if we go into Medicare+Choice. Well, we will save some money, Dr. Garthwaite, if we take all your patients and put them in Medicare+Choice.

I am concerned that this be carefully addressed. Many of the veterans have Medigap policies. And if they participate in the dem-

onstration and, for whatever reason, it doesn't work out for them—transportation might be a great area. If you have got to go to Livermore, then nobody lives within 100 miles of the Livermore hospital. I used to live across the street from it, and you could shoot cannons down the road and never hit a car. And there is no bus service.

They may decide that is inconvenient and want to go back, to say, some plan where Medigap—and they may have danger getting their Medigap, or trouble getting their Medigap policies back. And I think we should make sure that if they enter into these demonstrations, and, for whatever reasons it doesn't work out, they can be made whole with the benefits they would have had under Medicare.

I look forward to exploring some of these issues and as we hear about the success of socialized medicine in the United States.

Mr. Chairman, thank you for holding the hearing.

[The opening statement follows:]

Opening Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Mr. Chairman:

I gather this is largely a repeat of last year's effort.

I just have to say, as I did last year, that I am glad that the Majority recognizes that government involvement in health care can be good. The VA system, of course, is pure socialism, and it is interesting to see Members want to expand a socialist health system, rather than have Veterans use the civilian Medicare system.

I think the VA and DoD hospitals do a good job, and I just wish that all of America's 43 million uninsured could be subject to the same degree of socialism.

These various subvention bills do raise questions about how we can guarantee quality care for these Veterans, in that the payment will be less than what we are paying private sector Medicare HMOs. I am also concerned that veterans who have medigap policies not be disadvantaged by participating in this temporary Demonstration project. There is the danger they may give up their medigap policies, and then have trouble getting them back at a decent price.

I look forward to exploring these kinds of issues in the hearing and mark-up.

Chairman THOMAS. I thank the gentleman, and I don't normally respond to the Ranking Member's comments, but last time I checked my history book, those veterans who fought at Bataan and Iwo Jima were fighting fascists, and not communists. But that is OK.

Mrs. THURMAN. Mr. Chairman.

Chairman THOMAS. That's about as accurate as the rest of the statement. And we will leave it at that. [Laughter.]

Mrs. THURMAN. Mr. Chairman.

Chairman THOMAS. Not usually responding to my colleague.

Mrs. THURMAN. Mr. Chairman.

Chairman THOMAS. I will tell the gentlewoman that normally the Chairman and the Ranking Member make opening statements, and any other Member that wishes to make an opening statement can do so in a written form, but as a new Member of the Subcommittee, if the gentlewoman has some point to make.

Mrs. THURMAN. Actually, it is not a point, but Lane Evans had asked me if I could put a statement, a letter, that he would like to have on the record.

Chairman THOMAS. Oh, absolutely. Without objection, the Ranking Member of the Veterans Committee's statement will be placed in the record.

[The prepared statement follows:]

Statement of Hon. Lane Evans, a Representative in Congress from the State of Illinois

Mr. Chairman, unfortunately, a very important meeting with the Administration deters me from appearing before the Subcommittee, but I want to thank you for holding this hearing and allowing my statement to appear in the record. Veterans' Medicare Subvention is an issue that the Committee on Veterans' Affairs explored in the 103rd, 104th and 105th sessions of Congress. We have learned much since we began to investigate the implications of Medicare Subvention for veterans, VA, and the Health Care Financing Administration. As the Democratic Ranking Member of the Committee on Veterans Affairs, I want to articulate the view of many on that Committee.

In the first session of the 105th Congress, many Members joined me and Chairman Stump in supporting H.R. 1362. The bill enjoyed unanimous, bipartisan support on the Committee on Veterans' Affairs which reported the bill favorably to the House by voice vote on May 21, 1997. As you are aware, the bill was also referred to your Committee which has primary jurisdiction, but no further action was taken during that session of Congress and, unfortunately, the bill was never considered by the House. When the Senate voted on passage of the Balanced Budget Act of 1997, however, a provision similar to H.R. 1362 was included, but later died in conference.

This year the Senate has also moved legislation which contains a provision similar to one in the Chairman's H.R. 3828 which would authorize VA to serve as a provider to higher income (Category C) veterans who enroll in Medicare+Choice plans, but which also allows VA to establish a fee-for-service option for Category C veterans. The Senate measure, which passed as part of S. 4, does not include a program expansion for Category A veterans. Early in this session, Mr. Pickering and Mr. Moran, who serves on the Veterans' Affairs Committee, introduced H.R. 1347 which is similar to the Senate measure.

Early in this session, Mr. Rangel, Mr. Dingell and I sent a letter to Chairman Archer asking him to include Democrats in developing any legislation to be considered by your Committee. Our request was simple: if you choose to address Medicare Subvention in the 106th Congress, please involve us in the process. We further outlined some key components that would better assure bipartisan support for such a proposal. Quoting from the letter to Chairman Archer dated January 26, 1999:

> "First, Medicare Subvention should offer VA health care to Medicare-eligible veterans who have not previously had access to the system-it should serve as a new option for veterans with Medicare coverage. Second, we believe legislation should ensure that Medicare is able to reduce its expenditures for care received by Medicare-eligible veterans who are treated by VA. The legislation should not present a significant risk to the Medicare trust funds, nor should it compromise the funding Congress provides VA to care for veterans with disabling conditions related to military service and medically indigent veterans. VA should certify that it is able to provide care to Medicare-eligible veterans at a cost not exceeding its reimbursement from Medicare. If these criteria were met, Members would have strong incentives to enact VA-Medicare subvention legislation. We would be pleased to work with you in developing such legislation."

Unfortunately, to date, I have not received a response to that letter and I am not aware of any response made to the other co-signers.

My point in outlining this history is to convey both the long-standing interest of the Committee on Veterans Affairs in this issue and to identify another option, which enjoys widespread bipartisan support, for your Subcommittee's consideration. With all due respect, I believe the Senate passed version of VA Medicare Subvention is a much better bill than the bill which the House passed as part of H.R. 4567, the Medicare Home Health Act in the 105th Congress.

Make no mistake, VA desperately needs new sources of revenue. If the President's Budget is enacted for FY 2000, VA will enter its fourth consecutive year with no real growth. Our Committee recommended a $1.7 billion addition to the VA Medical budget; Democrats recommended an even larger increase of $2.3 billion. I hope that the Appropriators will enhance the funding we anticipate for FY 2000, but I am se-

riously concerned about this prospect if Congress does not break the caps imposed by the Balanced Budget Act.

Concerned as I am about the prospects for an adequate appropriation, I am sure many of this Subcommittee's members share my concern that VA's costs are covered by fairly and accurately billing the Health Care Financing Administration. As the General Accounting Office will undoubtedly share with you today, DOD's experience urges caution in implementing Medicare Subvention. DOD has had more experience with administrating contracts for managed care than VA and VA's problems with billing and collecting from third party insurers are chronic and severe. The Senate bill would give all of us better assurance that Subvention was working for veterans, for VA, and toward the sustenance of the Medicare trust funds. It is a much more limited bill than H.R. 4567. It is a three-year demonstration pilot limited to $50 million dollars and 10 VA sites. The Congressional Budget Office (CBO) scored the bill at $70 million over the life of the demonstration. If you recall, CBO scored the provision in H.R. 4567 at $1.7 billion—a very big difference.

Veterans prefer S.4. I have asked my staff to advise veterans' service organizations that your Committee is re-engaging Medicare Subvention. Some veterans' groups have previously indicated that they have serious concerns that H.R. 4567 would have compelled high-priority veterans who have been VA beneficiaries to enroll in Medicare and become its beneficiaries and, therefore, subject to the same premiums and copayments. Others share my concern that the Office of Management and Budget may be all too anxious to offset anticipated revenues from the VA appropriation. Many groups also express concerns about offering managed care, but not fee-for service care as an option. In testimony before the Senate Finance Committee last month, Paralyzed Veterans of America said,

> Medicare-eligible veterans who are not currently receiving services in the VA must be allowed the opportunity to over come past VA disenfranchisement [by virtue of income] by participating on an equal footing with current Medicare beneficiaries, choosing either managed care or continued participation in a fee-for-service arrangement.

I share PVA's view that fee-for-service will allow a fair test. I also share the concern expressed by at least one expert in the American Geriatric Society's Proceedings, that managed care does not always allow chronically ill or disabled, elderly people who rely on specialized care, the best option for their health care.

I want to urge your Subcommittee to take these concerns into consideration in identifying the appropriate legislative vehicle for Medicare Subvention. I want to thank Ranking Member Stark for keeping me and my staff apprised of the Subcommittee's proceedings.

Mrs. THURMAN. Thank you.

Chairman THOMAS. And we have with us Dr. Berenson from the Health Care Financing Administration. He is the Director for the Center for Health Plans and Providers at HCFA, and Thomas Garthwaite, who is the Deputy Under Secretary of Health for the Department of Veterans Affairs.

Dr. Berenson, any written statement you have will be made a part of the record, similarly with Dr. Garthwaite. And you may address us in any form you see fit in the time you have available.

STATEMENT OF ROBERT A. BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BERENSON. Thank you, Mr. Chairman, Congressman Stark, and other Members of the Subcommittee. I will just give a very brief opening oral statement. I have provided a written statement. Thank you for inviting us to discuss our Medicare subvention for beneficiaries eligible for veterans benefits.

The Veterans Administration and HCFA signed a memorandum of agreement in May which details how the project would work, and we are eager to move forward as soon as legislation is enacted authorizing us to do so.

Subvention has the potential to benefit all parties involved, most importantly, the beneficiaries who are eligible for both Medicare and military or veterans benefits. The Clinton administration strongly supports these demonstrations, and we are committed to meeting the challenges they present.

We are focusing on two imperatives: protecting beneficiaries and protecting the Medicare Trust Funds. The VA demonstration would be modeled on a DOD demonstration that has been up and running since August 1998. It is important that they both rely on a coordinated care model. Focusing on coordinated care will promote higher quality care. It will limit costs and the administrative burden. And it will provide consistency between the two demonstrations, permitting us to learn more about how these demonstrations benefit the beneficiaries.

Demonstration sites will—must meet all conditions of participation required of Medicare+Choice coordinated plans, except for those such as fiscal soundness rules that are clearly not applicable to the military or to the VA.

The GAO has identified important concerns about the DOD demonstration, and its estimate of the level of effort that is critical to protecting the trust funds and ensuring that taxpayers don't pay twice for the same services.

We are working to address these concerns with the DOD, and we are heeding the lesson learned in focusing more on data systems and the level of effort estimate up front as we move forward with the VA demonstration.

We are committed to learning as much as we can from these projects. We have hired an outside contractor to assess the DOD demonstration's impact on costs, access, and quality, as well as any effects on providers and other Medicare beneficiaries in the surrounding community. We will have a similar evaluation conducted for the VA demonstration.

We look forward to working with this Subcommittee, the DOD, and the VA as we continue. Together we can limit the risks and ensure top-quality care. And in the end, we should all benefit.

Thank you very much.

[The prepared statement follows:]

Statement of Robert A. Berenson, M.D., Director, Center for Health Plans & Providers, Health Care Financing Administration, U.S. Department of Human Resources

Good morning, Chairman Thomas, Congressman Stark and members of the Committee, thank you for inviting us to discuss our demonstration for Medicare subvention involving our nation's veterans. I would also like to thank the General Accounting Office (GAO) for its valuable evaluation of the Department of Defense (DoD) subvention demonstration project, which provided information that is helping us to better plan for the Veterans Affairs (VA) subvention demonstration.

In recent weeks we have been reminded once again of the contributions America's veterans have made to our country. We are committed to working with the VA to see if there is a way to improve their access to care while protecting the Medicare Trust Funds. The Clinton Administration strongly supports this demonstration. I want to update you on the status of these demonstrations and to explain the need to limit the Veterans Affairs demonstration project to coordinated care.

The term "subvention" refers to Medicare paying for care provided at military, veterans or other federal facilities to Medicare beneficiaries. Medicare is precluded by statute from doing this. The Balanced Budget Act of 1997 authorized a 3-year, demonstration for military retirees and an implementation plan for a similar veterans demonstration. Enrollment in the DoD demonstration began in August 1998, and we signed a Memorandum of Agreement with the Department of Veterans Affairs on the VA demonstration in May 1999. These demonstrations provide the opportunity to assess how a coordinated approach to subvention might improve efficiency, access, and quality of care for Medicare-eligible military retirees and veterans. In implementing the DoD demonstration and drafting the memorandum of agreement with the VA, we focused on two imperatives: protecting beneficiaries and protecting the Medicare Trust Funds.

DOD SUBVENTION DEMONSTRATION

The DoD demonstration has valuable lessons to offer for the VA project. It creates a DoD-run HMO, TRICARE Senior Prime, in six sites for military retirees and their dependents who are eligible for Medicare. The TRICARE Senior Prime Option provides a full range of Medicare benefits to enrollees. Covered services include the standard Medicare benefits plus other TRICARE benefits such as pharmaceutical coverage. Enrollees agree to receive all covered services through TRICARE. DoD must spend as much for the care of those in the demonstration areas as it already spends on them, known as its "level of effort." Prior to this, dually-eligible beneficiaries could only be treated at DoD facilities on a "space available" basis. After the DoD has met its level of effort, Medicare pays 95 percent of the rate it pays for Medicare+Choice plan enrollees, minus medical education, disproportionate share payments, and a portion of hospital capital payment costs. Medicare payments are capped at $50 million in the first year, $60 million in the second year, and $65 million in the third year.

The GAO has raised two important concerns about the DoD subvention demonstration:

- DoD's estimates of its level of effort may be over or underestimated; and
- Data problems and payment issues could make the demonstration difficult to manage at both the national and local levels.

We are working with the DoD to address these concerns, and hiring an outside contractor to help review DoD data and methodology.

We have contracted with RAND, Inc., to evaluate the DoD demonstration, including the:

- impact on the costs to both the Medicare Trust Funds and DoD;
- whether there is improved access to care;
- any change in quality of care provided to the demonstration population; and
- any impact on providers and other Medicare beneficiaries in the surrounding community.

We expect the first interim report on this evaluation this month, with a final report in December of 2001. The GAO will also conduct an evaluation for the HHS Inspector General.

VA DEMONSTRATION

We are working toward implementation of a similar Veterans Affairs subvention demonstration, in preparation for enactment of legislation that would be required to authorize implementation. As with the DoD project, Medicare will pay for care in the VA health care system for Medicare beneficiaries who are also eligible for VA health care benefits. We believe this could provide more access to VA services for veterans, savings to the Medicare Trust Funds, and administrative efficiencies to both programs.

The memorandum of agreement between HCFA and the VA is modeled on the DoD demonstration and, like the DoD demonstration, relies upon a coordinated care model. Medicare will reimburse the VA for health services provided by VA in a coordinated care model to Medicare beneficiaries who are Priority 7 veterans (generally those without a service-connected disability who are above the VA income threshold). Beneficiaries who enroll in the demonstration will be able to use their Medicare benefits to obtain Medicare coordinated care services at VA facilities and other sites under contract to the VA. The VA organization will provide the complete range of Medicare benefits, and adhere to the conditions of participation and quality standards required of Medicare+Choice plans. As with the DoD, the VA will receive Medicare payments only after it surpasses its current level of effort for dual-eligible beneficiaries in demonstration site facilities. After the VA meets its level of effort, Medicare will reimburse the VA at the rate of 95 percent of county-based

Medicare+Choice capitation rates, excluding medical education, disproportionate share payment, and a portion of hospital capital payment costs. As we are able, we will risk adjust payments to take into account enrollee health status.

We have taken care in designing this demonstration to protect the Medicare Trust Funds. If Medicare costs are more than they would have been without the demonstration, Medicare and the VA have agreed to take any necessary corrective action. For example, the VA may refund Medicare payments, we may suspend or terminate the demonstration, or we may adjust payments. To further insulate Medicare from financial risk, a "cap" of $50 million a year will be placed on the total Medicare reimbursement to VA. Furthermore, the VA has agreed to open its facilities to audits by HCFA and the HHS Inspector General.

We have addressed issues the GAO identified in its evaluation of the DoD demonstration in our planning of the VA demonstration. For example, as with the DoD subvention demonstration we plan to base the level of effort calculation on actual expenditures the VA made during a specified base period. We are working with the VA to make sure we have the information we need to make accurate and reliable payments based upon a valid baseline.

Thus, we strongly believe that we have taken all possible steps to protect beneficiaries, the Trust Funds, and the VA from any potential adverse outcomes. And, as with the DoD demonstration, we will solicit a rigorous evaluation by an independent evaluator. Over the 3 years of the demonstration, the independent evaluator will monitor performance and collect data on:

- impact on the costs to either the Medicare Trust Funds or VA;
- whether there is improved access to health care;
- any change in quality of care provided to the demonstration population; and
- any effect on local health care providers and other Medicare beneficiaries in the surrounding community.

Focusing on Coordinated Care

The DoD demonstration is limited to coordinated care by statute and, for good reasons, we have limited the proposed VA demonstration to coordinated care. This will:

- promote higher quality through better coordinated care;
- protect the Medicare Trust Funds;
- limit the administrative burden; and
- provide consistency between the two demonstrations.

Under a coordinated care model, enrollees would obtain all services from or through the VA. This will ensure that all needed care is received from the appropriate providers who have access to patient records and other needed patient information. We believe it will help ensure that beneficiaries receive high quality, coordinated care. It will help the VA better anticipate costs and payment amounts, resulting in better planning and improved access to care. It also means the demonstration will more likely remain within the spending caps established in the memorandum of agreement, thereby minimizing the likelihood that participation will be curtailed later in the demonstration. And a coordinated care model also will better protect the Medicare Trust Funds by removing many of the unknowns and risks inherent in a fee-for-service model. Focusing on one model will also minimize the administrative burden. Our memorandum of agreement with the VA is similar to the one with the DoD and, our role is similar in both. Therefore, we can leverage the staff, resources, and lessons learned between the two projects. But that can only be achieved with some level of consistency between the two programs.

I would like to alert the Committee that it does take a long time to implement a demonstration of this complexity. With the DoD demonstration receiving high-priority implementation treatment from both HCFA and DoD, it took between 13 and 17 months to deliver services in sites after passage of authorizing legislation.

Conclusion

Subvention has the potential to benefit all parties involved—the VA, Medicare and, most importantly, beneficiaries eligible for both Medicare and veterans' health care benefits. They should enjoy enhanced choice and improved service, which is the true "bottom line" in this effort. The President strongly supports this demonstration, and we are committed to meeting the challenges it presents and learning as much as we can about what would be necessary to expand such a program. We look forward to working with this Committee and the VA as we continue to seek to improve health care services available to our nation's Medicare-eligible veterans. It is critical that we limit the risk to VA and the Trust Funds, and ensure top quality care to veterans. In this regard, we recommend limiting the demonstration to coordinated

care only, and stress the importance of allowing for about a 1-year implementation period.

Chairman THOMAS. Thank you very much, Dr. Berenson.
Dr. Garthwaite.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., ACTING UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. GARTHWAITE. Thank you, Mr. Chairman, Members of the Subcommittee. I want to thank you for the opportunity to testify on behalf of the Medicare subvention pilot at the Department of Veterans Affairs.

VA has sought this authorization for a number of years, because we believe this would be beneficial to both the veterans who would like to use their Medicare benefits through the VA health care system and the Medicare Trust Funds themselves. We greatly appreciate your leadership on this issue in the 105th Congress.

Medicare subvention is an issue of equity for Medicare-eligible veterans. In VA's view, veterans should have the opportunity to use their Medicare benefits at VA health care facilities if they choose. Moreover, VA believes allowing veterans to have this option represents significant potential savings since VA has agreed to provide Medicare coverage services at a discount.

So that the subvention pilot can be implemented expeditiously, we have worked with the Department of Health and Human Services and successfully designed a memorandum of agreement that establishes a foundation for a VA Medicare pilot that will serve as the framework of an implementation plan as we move forward in this effort.

This agreement addresses concerns that have been expressed in the past about the financial risk of increased cost in Medicare Trust Funds and VA's capabilities to successfully meet Medicare requirements and operate as a Medicare provider.

As you are aware, VA has undergone a significant transformation in our health care structure and our service delivery in these past few years. The infrastructure and processes now in place to enable VA to successfully meet—now enable VA to successfully meet all Medicare requirements.

While training and education will still be required, we have made enough changes to have the faith that our health care managers have demonstrated that they can meet the challenges of the Medicare subvention legislation.

On the administrative side, VA has experience in billing third-party insurance companies under the medical care cost recovery program. We do understand that we have some shortcomings in our documentation and coding, and have aggressively taken steps to address these concerns.

Necessary changes will be implemented by September 1999, when we also implement a reasonable-charge billing structure similar to private-sector providers.

On the clinical side, VA already offers a full range of services that must be offered under any Medicare Program. Services are

available either directly at VA facilities or through contractual arrangements, since VA's contracting authority permits us to provide any services that are required and not readily accessible.

We have universal primary care, and we practice coordinated care across the entire continuum of services. I believe that it is this coordination of care in which we manage the care itself, not just manage costs, that is critical in our evolution of health care and is critical in making the managed-care model that has been proposed successful.

Managed care has not done enough to make the care more coordinated and more convenient and more coherent, which is critically important to actually improving health care outcomes. If we focus on managing care to produce higher quality, then costs will decrease, for higher-quality care actually costs less.

The Medicare pilot, which VA and HCFA are proposing, would be for dual-eligible veterans who are classified as Priority 7; that is those veterans with higher incomes who have no service-connected disability or service-connected disability that does not entitle the veteran to compensation.

Our MOA, memorandum of agreement, includes only a Medicare+Choice pilot. This is the direction that the VA health care has gone and has been heading in the last 3 years, and one which offers the best opportunity to provide comprehensive, coordinated care for our enrollees. This is also the mode of health care delivery which Medicare beneficiaries have increasingly been choosing.

The current MOA does not include a fee-for-service option. VA's concerns are that adding a fee-for-service demonstration would limit VA's ability to coordinate all care that veterans receive and that a fee-for-service demonstration entails additional data requirements. Implementing both fee-for-service and coordinated-care demonstrations simultaneously would introduce greater administrative complexities and resource requirements.

Nevertheless, as VA has attested to previously before Congress, including a fee-for-service option is not a deal breaker for us, it might be tougher, but we would rather get moving on this because we believe in it strongly.

In conclusion, I am confident both the VA and Medicare will gain from this pilot experience. I want to assure the Subcommittee of the importance that VA places on this Medicare subvention initiative. VA will devote its energy and its resources to ensuring that the pilot is successful, both for VA and for Medicare, and that every veteran who comes to the VA will receive high-quality care.

Again, thank you for the opportunity to appear here today. I will be pleased to answer any questions you or the Subcommittee might have.

[The prepared statement follows:]

Statement of Thomas L. Garthwaite, M.D., Acting Under Secretary for Health, U.S. Department of Veterans Affairs

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on behalf of a Medicare Subvention pilot for the Department of Veterans Affairs. VA has sought authorization for Medicare reimbursement for a number of years because we believe this would be beneficial to both the veterans who would like to use their Medicare benefits through the VA healthcare plan and, importantly, to Medicare and the Medicare Trust Funds.

Medicare Subvention is an issue of equity for those Medicare-eligible veterans who can use their Medicare benefits at Medicare-certified health care providers in the community, *except* at VA healthcare facilities. In VA's view, this represents significant potential savings since VA has agreed to provide Medicare-covered services at a discount, and we welcome the opportunity to test if the savings can be realized.

VA and the Department of Health and Human Services successfully designed a Memorandum of Agreement (MOA) that establishes the foundation for a VA Medicare Subvention pilot and will serve as the framework of an implementation plan as we move forward in this effort. This agreement addresses concerns that have been expressed in the past about the financial risk of increased cost to the Medicare Trust Funds and VA's capability to successfully meet Medicare requirements and operate as a Medicare provider. When I discuss the MOA in more detail, I will cover the safeguards that have been included to protect the Trust Funds.

First, however, I would like to address concerns about VA's ability to be a Medicare provider, by describing the fundamental transformation that the VA healthcare system has undergone in the last four years. I know that some of you are already aware of this transformation. However, for those who may not be as familiar with the VA healthcare system, I hope this gives you a new perspective on VA.

In 1994, VA was a hospital centered healthcare system that had not kept pace with the changes in healthcare that were occurring in all of American healthcare. VA recognized that it had become an outdated, unresponsive, and inefficient healthcare system that could better serve its patients. To address these issues, the veterans healthcare system initiated a systemic and systematic effort to fundamentally re-invent itself. In the process, the Veterans Health Administration (VHA) has become the largest fully integrated healthcare system in the nation, delivering a full continuum of services. The effort has involved reengineering VHA's operational structure, streamlining its processes, implementing "best practices," improving information management, reforming eligibility rules, expanding contracting authority, and changing the culture of VA healthcare. I can tell you today, without reservation, that no other healthcare system in the U.S. can match either the extent or rapidity of change that has occurred in the veterans healthcare system since our reinvention effort was launched in late 1995.

To illustrate the nature of VHA's transformation, let me cite a number of facts and figures that attest to the nature of the improvement that has occurred:

- VA's now approximately 1,100 sites of care delivery have been organized into 22 Veterans Integrated Service Networks (VISNs) and these networks are now the system's basic operating unit.
- Beginning with about 10 percent of VA patients enrolled in primary care in 1994, universal primary care has been implemented, as well as universal telephone triage of "call centers." In a recent survey, almost 90 percent of patients could identify their primary caregiver.
- Since September 1994, 54 percent (28,195) of all acute care hospital beds have been closed.
- Compared to FY 1994, annual inpatient admissions in FY 1998 decreased 32 percent (288,398 fewer admissions), while ambulatory care visits increased by 35 percent (10.3 million increase for a total of 35.8 million outpatient visits in FY 1998).
- From October 1994 through September 1998, bed days of care per 1,000 patients decreased 62 percent—from 3,530 to 1,333.
- Cumulative levels of staffing have decreased 12 percent (25,073) since 1994, even though we provided hands-on care to 520,000 (22 percent) more patients in 1998 than in 1994.
- Ambulatory surgeries have increased from 35 percent of all surgeries performed in FY 1995 to about 75 percent of all surgeries now. Associated with this has been increased surgical productivity and reduced mortality.
- A new capitation-based resource allocation methodology (the "Veterans Equitable Resource Allocation" system) has been implemented and validated. This has brought much needed financial discipline to the system.
- Customer service standards have been implemented, customer satisfaction surveys are being routinely performed, and management is being held accountable for improving service satisfaction. Statistically significant improvements have been documented. In FY 1998, 65 percent of all patients, including psychiatric patients, reported the quality of their care as very good or excellent.
- A pharmacy benefits management program implemented in FY 1995, which includes a national formulary, has produced an estimated $347 million in annual savings simply on the purchase of pharmaceuticals.
- Other elements of a Commercial Practices Initiative are yielding tens of millions of dollars of savings in the acquisition of medical and surgical supplies, pros-

thetics, equipment and maintenance, renal dialysis, and support services. (Indeed, a number of GAO reports have documented VA's marked savings in this regard compared to Medicare.)

- Over 270 new community-based outpatient clinics (CBOCs) have been sited, or are in the process of being sited, from savings achieved in other areas. Many of these are by contract with private providers.
- Major initiatives have been launched to increase care management, end of life care, pain management, use of clinical guidelines, and home care.
- A multi-dimensional, process-and outcome-focused quality of care accountability framework has been implemented to ensure the consistency and predictability of high quality healthcare being delivered everywhere in the VA system, and VHA has been designated as a national laboratory for healthcare quality management by the National Partnership for Reinventing Government.
- Universal pre-admission screening and admission and discharge planning have been implemented, along with many other "infrastructure" and processes changes, such as a universal semi-smart identification and access card.
- Significant improvements in the quality of care have been demonstrated, and in a number of areas, VA's performance is significantly better than that of the private sector.

I am proud of these accomplishments and anticipate that VA will continue to make significant gains as its transformation matures. I believe these changes demonstrate that the infrastructure and processes are in place to enable VA to successfully meet all Medicare requirements. Training and education will be required at our pilot sites so that our healthcare providers and administrators become fully knowledgeable about specific Medicare requirements. However, the success that VA healthcare managers have demonstrated in meeting the challenges of the past four years shows that they are up to the Medicare challenge. Implementation of the demonstration will require us to address a number of important administrative issues. HCFA's knowledge and experience in this area will be helpful in addressing the issues and setting an implementation timeline.

VA already offers the full range of services that must be offered under any Medicare program. The services are available either directly at VA facilities or through contractual arrangements. VA's contracting authority permits us to provide any services that are required and not readily accessible. VA has experience in billing third-party insurance companies. Through internal reviews we have become aware of some shortcomings in our documentation and coding, and we have taken aggressive steps to address these concerns. Necessary changes will be implemented by September 1999, when we also implement a "reasonable charge" billing structure similar to private sector providers. We are able to generate the Medicare required UB92's and HCFA 1500's, and implementation of our Decision Support System in all our facilities gives us an enhanced capability to track costs.

On the clinical side, we have universal primary care, and we practice coordinated care across the entire continuum of healthcare services. I believe that in the coordination of care, we must manage care, not costs. It is becoming increasingly clear that the greatest failure of managed care has been that it has focused on managing cost, without actually improving care. Too often, managed care companies have addressed only the symptoms of the ills that afflict private healthcare; they have not addressed the basic pathology of fragmented, provider-focused and user-unfriendly services, and redundant and excess capacity. So far, managed care has not done enough to make care more coordinated, more convenient and more coherent (i.e., to manage care so that is actually improves outcomes). If we focus on managing care to produce higher quality, then costs will decrease, for I believe that higher quality care actually costs less.

The importance of coordinating a patient's entire care is one reason that I advocate a Medicare+Choice model for the VA Medicare Subvention pilot. Through this model we can be sure that we have a well-managed, well-coordinated approach to our veterans' healthcare needs. VA's current use of coordinated care puts us in an excellent position to successfully operate a Medicare+Choice plan. In addition, VA's high proportion of elderly mirrors the population that would enroll in a VA Medicare+Choice plan.

The Medicare Subvention pilot which VA and HCFA are proposing would be for dual-eligible veterans who are classified as Priority 7—that is, those veterans with higher incomes who have no service-connected disability or a service-connected disability that does not entitle the veteran to compensation. If VA is unable to treat all eligible veterans because of resource constraints, Priority 7 veterans would be the first to be cut off from care. Although we have been able to offer healthcare services to this group of veterans in FY99, this is subject to an annual determination. The authorization for these veterans to bring their Medicare benefits to VA would

assure them access on a continuing basis and improve equity of access during the duration of the demonstration. In many cases, Medicare subvention would allow VA to treat veterans who otherwise would be getting either fragmented care or no healthcare at all.

Historically, the Priority 7 veterans have made up a relatively small proportion of those who use the veterans healthcare system—about 3 or 4 percent. Although the numbers have increased in recent years and continue to increase under our current enrollment process, the proportion of users is still slightly below 10 percent. Costs associated with the care of this group of veterans have been less than that of the higher priority groups since they tend to use fewer and less costly services. Nevertheless, both VA and HCFA realize that appropriated dollars have been spent to provide care for this population. For this reason, the Memorandum of Agreement contains a provision to establish a Level of Effort (LOE) which represents what VA has spent in the past to deliver Medicare-covered services to these veterans. Payment from the Medicare Trust Funds will be made only after the LOE is reached. Although it is difficult to make precise LOE calculations, the estimates will be based on the cost data that are available. Because of the relatively small numbers of Priority 7 users, VA does not anticipate that the LOE will represent a substantial amount at any one pilot site.

Our MOA includes only a Medicare+Choice pilot. This is the direction that the VA healthcare plan has been heading over the past three years and one which offers the best opportunity to provide comprehensive, coordinated care for our enrollees. This is also the mode of healthcare delivery which Medicare beneficiaries have increasingly chosen. The adoption of this approach does not preclude establishing a pilot in a rural area. I believe a rural site should be given consideration as it could provide some valuable insights for both VA and HCFA. Adding a fee-for-service demonstration would limit VA's ability to coordinate all care that veterans receive. A fee-for-service demonstration entails additional data requirements. Implementing both a fee-for-service and coordinated care demonstration would introduce greater administrative complexities and resource requirements.

Several things should be said about the various concerns that have been raised in regard to risk to the Medicare Trust Funds as a result of the pilot. First, this is a limited pilot. The MOA is proposing that the demonstration be limited to eight sites or two Veterans Integrated Service Networks (VISNs). In addition, the cap on the reimbursement from the Trust Funds is $50 million annually. This does not mean that the risk to the Trust Funds is $50 million, as this represents compensation for services that VA is providing and that Medicare would have to reimburse any other Medicare provider to provide healthcare services to these same veterans.

Moreover, there are provisions in the MOA that provide additional protections to the Trust Funds. In addition to the "cap" on Medicare payments, there is the level of effort calculation, an annual reconciliation with the LOE, an end of year reconciliation to assure accurate payments and data calculations, and a mechanism to make adjustments or even end the pilot if ongoing analyses and evaluations identify unacceptable costs to either VA or to the Trust Funds. Beyond these safeguards, the payment, which VA has agreed to accept, represents a discount to the Trust Funds compared to private sector rates. The rate is based on 95 percent of Medicare normal payments to the private sector, along with exclusion of DME, IME, DSH, and two-thirds of capital. Compared to the annual national Medicare Trust Funds expenditures, I believe the VA Medicare Subvention proposal does not represent a threat to the Trust Funds, but offers an opportunity to realize savings. I am confident that both VA and Medicare will gain from this pilot experience. Our MOA includes requirements for several studies by the GAO and independent evaluators to measure the actual impact to the Trust Funds.

In conclusion, I want to assure the Committee of the importance that the Secretary and I place on this Medicare Subvention initiative. VA will devote its energy and resources to ensuring that the pilot is a success—for both VA and Medicare—and that every veteran who comes to VA will receive quality healthcare. I am confident that both VA and HCFA have the desire, resourcefulness and expertise to work together as partners to achieve the objectives that are embodied in the Memorandum of Agreement and in the VA Medicare Subvention pilot.

Chairman THOMAS. Thank you, Doctor.

Dr. Garthwaite, what is the mission of the Veterans Administration?

Dr. GARTHWAITE. We have four statutory missions, to provide high-quality health care to veterans, to produce research, and education, and to back up the Department of Defense in the national disaster medical system.

Chairman THOMAS. That's a statutory answer, but if you were to go out and tell someone why we still have a Veterans Administration, what is that the Veterans Administration is supposed to do that would justify a separate, Cabinet-level department status?

Dr. GARTHWAITE. I think that gets to the issue raised by Mr. Stark as well.

Chairman THOMAS. Oh. Does it? Appreciate the observation.

Dr. GARTHWAITE. I believe that there is a unique VA system for several very important reasons. One is that veterans have a higher proportion of certain diseases that are not well covered in the private sector.

Chairman THOMAS. Now how would that be addressed by your argument that this proposal was going to go to Priority 7, who are higher income, nonservice-disability veterans?

Probably not meet that test, don't you agree?

Next reason you would tell someone why there is a separate Cabinet-level department for veterans would be what? And if you catch my drift, you are going to have trouble finding a second one that justifies high-income, nonservice disability, as your reason for continued existence as a separate department at the Cabinet level.

So why should you be separate? Running a separate health care system for people who otherwise will be getting health care, and are in fact doing both HMOs outside and, where convenient, using the VA, and they have no service-based disability at all.

What is the justification for your continued separate existence or entering into an arrangement which draws those people who would otherwise be mainstreamed by choice into sustaining your system, which in terms of the core reason for its existence ought to be to help those people, in my opinion, to help those people who went in harm's way, sometimes not by their own choice, who have no wherewithal to get health care elsewhere because this society promised them we would take care of them and/or their disability is clearly service related?

Yet virtually the entire thrust of your testimony, including the gratuitous fee-for-service option that you just said you would have no problem with, means what you are trying to do is run a parallel health care system with no rationale.

And now I agree completely with my colleague from California. There is no reason for us to run, finance, or maintain a socialist system for higher income, nonservice-disability folk who just happen to have been veterans.

Dr. GARTHWAITE. If I could make a point about that, I believe we maintain the system for the people you describe, for those that are lower income and for those that have disabilities related to the service of their country. As we do that, we are required to maintain a level of services through both cost and doing enough services to maintain quality. It is easier to run that system and maintain the services that aren't provided in the private sector if we have enough patients going through the system to maintain its vigor.

Chairman THOMAS. All you got to do is just open your door and let anybody use the hospitals that chooses to use them so that you could compete with all the other hospitals. Then you could get—if you have quality, people will come to your door.

But I have a really difficult time understanding how you are going to meet the mission of low-income, service-disabled veterans with a fee-for-service program. I mean, that group is the antithesis of folk who would be able to make use of a fee-for-service program.

Dr. Berenson, where is HCFA? The last time I think we talked, you folks were not real wild about a fee-for-service aspect for this, that we were looking at a coordinated care structure.

Dr. BERENSON. Well, we feel very strongly that it would be a mistake to proceed on a fee-for-service demonstration, that would be administratively very difficult. But more importantly, the emphasis of Dr. Kizer and what's happened in the last few years with the VA has been to promote coordinated care. It is consistent with the Medicare+Choice Program.

And so we would feel very strongly that it is important that we demonstrate a Medicare+Choice-type approach and not a fee-for-service one.

Chairman THOMAS. Thank you. And I know you referenced it in your testimony, Dr. Garthwaite, that the VA has some shortcomings in its billing and accountability. And obviously we are going to have the GAO up in a minute, and I think that is probably, that is kindest way to put as I can think. There are some shortcomings.

The real problem that a number of us have is your ability—not that you wouldn't do it—but your ability to demonstrate that you would not take precious Medicare money and support higher income, nonservice-disabled veterans and reduce quality care elsewhere just to maintain what I clearly hear from you is an outreach program to try to keep people tied to the VA so that that Cabinet-level department can have a reason for being in existence.

One of the concerns a number of us have is that the VA is headed in the direction of the Department of Agriculture, where every bureaucrat there has a farmer and one dies they cry because that means you may have to reduce the department. It doesn't make any sense for you folks to argue, in my opinion, a fee-for-service without the ability to show where every dollar that you currently spend is spent for Medicare-eligible veterans and how any dollar that we or HCFA transfers to you, would not displace one of those dollars.

Now, how do you mean to respond to the GAO's criticisms, because, frankly, I believe unless you believe otherwise that the DOD criticisms are at least equally valid as applied to the VA. Or do you believe that you have a better accounting system than the DOD?

Dr. GARTHWAITE. By the end of this fiscal year, we will have fully introduced a decision-support system by TSI and in every one of our medical centers, which gives us a significantly better handle where each dollar is spent and on which patients and for which services.

We have been implementing this over the course of several years. Several of our networks are already up. And each of our facilities is entering data at the current time.

I believe that we will be in a good position to begin to meet those needs. Data are always an issue for us, but I think we get better every day. And I think the DSS will help us do that. It has been a significant part of our negotiations, how to do the documentation of that data as well.

Chairman THOMAS. I will tell the gentleman, using the analogies, by the time this is off the ground, that is one of the reasons folks are required to do preflight checks, so that you don't see if you have oil pressure when you are off the ground. I will tell you that, clearly, one of the preflight checks will be whether or not you can have a clear ability to determine where costs are, costs centers and dollars allocated, before you start rolling down the runway.

And it will not be a congressional decision. It will be accounting experts telling us that you in fact are able to do that which you cannot do now. We will not, if I have anything to do about it, go forward with the program that you hope you will have in place at the time it starts, the kinds of checks and balances that the GAO report says that you ought to have.

The gentleman from California.

Mr. STARK. Mr. Chairman, before I inquire of the witnesses, could I inquire of the Chair to see if our understanding is the same?

Chairman THOMAS. If I can respond.

Mr. STARK. My understanding is that this bill, that I guess we are going to consider for a demonstration, has a $480 million cost, for about 480 over 5 years and about $1.8 billion over 10 years, in that neighborhood. Are we on the same page?

Chairman THOMAS. No.

Mr. STARK. OK.

Chairman THOMAS. And this was last year's bill. We don't have that yet.

I believe the Senate's was about $200 million. I believe ours was around $300 million.

Mr. STARK. Million over 5 years?

Chairman THOMAS. Yes.

Mr. STARK. OK. And we don't have a pay-for as yet, is that right?

Chairman THOMAS. There is no bill. We had a pay-for in the last Congress, and, as the gentleman well knows, we will have a pay-for in this Congress. That is one of those preflight checks that are required.

Mr. STARK. That leads me to my questions. I have a VA study that suggests that approximately—this is 1996 data, but I presume it hasn't changed a whole lot—in 1968 we had about 60,000 VA patients over 65 who were also enrolled in Medicare HMOs. OK. They are going to the Veterans Administration for treatment but they are also at the same time enrolled in Medicare HMOs, which are paying the capitated rate for care.

The VA says that the services that the VA provided to these veterans cost—and should have been covered by the HMOs—cost the VA $146 million. I don't know whether the Chair is following me or if witnesses are following me, but we are, the government is already paying because these veterans are Medicare beneficiaries, we are paying for their HMO premium. And yet they are coming back to the VA for treatment, which the HMO should give them. And

somewhere—and these are VA's figures—about $146 million is falling through the cracks.

My question to the witnesses is, Dr. Garthwaite, is this a close approximation? And if it is, why aren't we collecting or billing the managed-care companies for this money?

Dr. GARTHWAITE. I am clearly aware of the study-analysis that you indicated. Yes, I think that with some nuances and discussions we are having with HCFA about the implications of this and what further things we can do about it, I would say it is probably pretty accurate. Currently, we rely on the veterans to tell us if they have additional insurance. So some do; some don't.

Where we have worked out arrangements with HMOs in one or two places now in the country, we have been able to bill them successfully. But mostly we haven't without a prepaid agreement or arrangement with HMOs. We bill all other insurers for services rendered under our medical care cost recovery for nonservice-connected conditions. I think it is a major issue that we have coordination of Federal benefits.

Mr. STARK. If we required that that be done, that would take care of paying for this, for a good part of this bill, would it not?

Dr. Berenson, does HCFA have a problem with this?

Dr. BERENSON. Yes. Our staff is actually working with Elliot Fisher and his colleagues, the group who wrote the study, where we provided some comments back, where we think there may be some methodologic problems, but we are not disagreeing with the thrust of the study. Dr. Kizer and I had initiated some discussions to try to sort of figure out what is going on here, but I think it is a legitimate area that we have to pursue.

Mr. STARK. And there is no procedural reason that we—do you need legislation to do this or this—I think we may hear from GAO later that we don't.

Dr. BERENSON. No. I don't believe so.

Mr. STARK. You need encouragement. [Laughter.]

Dr. BERENSON. Let me just note that there is a general issue that we are trying to understand now with regard to the Medicare+Choice Program. Recently, the Inspector General issued a report that showed that a number of beneficiaries, when they moved back from Medicare+Choice to fee-for-service have very high rates of hospitalization. In this situation, when they have concurrent, dual eligibility, they may be electively going to the VA hospital on their own for surgery or maybe something else is going on related to the incentives at the managed-care plan.

We are engaging in a survey on the first issue to try to figure out why beneficiaries are dropping out of plans and getting hospitalized in fee-for-service, and we really do need to understand whether the beneficiaries are exerting their choice to do this or whether something else is going on that is more of concern to us.

Mr. STARK. I have a second pay-for, Mr. Chairman, if this one doesn't work. And that is, I assume, Dr. Garthwaite, that you are no longer treating any veterans from the early American Indian wars.

Dr. GARTHWAITE. I believe that is true.

Mr. STARK. Because, even though they may have lost those battles, they found a way to provide pharmaceutical prescriptions to

about, I don't know, 250 million prescriptions a year, and they are able to sell these drugs at the same rate you're able to buy them. The Indians are entitled to purchase, under the Federal Supply Schedule, I think is the technical term, and because they can't resell them at a profit, they are charging a script fee of about $9. And, we don't know how much they are making. This is the Pequot Tribe, I believe, in Connecticut. Yes.

Now, but for the noneligible, because they also can't sell at your low rate to nonfederally eligible, which is mostly Medicaid beneficiaries, but they are doing such a good job and have such a deep discount that they are able to buy at the HMO discount rate, which is also substantially below what we have to pay for these prescriptions.

What about the VA taking a page out of the nations that you defeated and going in to provide pharmaceutical drugs? I mean, we are going to help you, is what you are after, help the veterans. How about you helping us, and opening up—you have a great pharmaceutical staff. You provide prescriptions, you purchase them, you are experts in it. You have got all the pharmacists on staff. The extra overhead of your operating a mail-order prescription for other Medicare beneficiaries wouldn't be very much, would it?

Dr. GARTHWAITE. We would be happy to look at that. Absolutely.

Mr. STARK. And if you made $9 a prescription, that could all go toward caring for us veterans. And nonveterans, like my mother, would be able to get a lower price on her prescriptions. We would have a win-win situation. You would make a lot of money providing a great service, and we would give you extra money for us veterans. And I just—if the Indians could do it, I surely would like to think that the Veterans Administration could do it.

Will you take that under consideration?

Dr. GARTHWAITE. Absolutely.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. If we could slip a lottery card into each one of those—[laughter]—then you would have matched the Indians across-the-board.

Do we want to go vote and then come back, because the bell just rang? It's 10 o'clock. Somebody could get a short five in, but you have been shorted on your questions a number of times. Let's go vote and come back. Good. Because we may have some followup questions.

The Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. The Subcommittee will reconvene.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Gentlemen, the various veterans subvention proposals are intended to have no net effect on Medicare spending. Is that correct?

Dr. BERENSON. We are working very hard to make sure both by requiring a level of effort from the Veterans Administration and putting a cap on how much money would be spent that we do not open up the trust fund to unanticipated spending.

Mr. MCCRERY. And the Secretaries of HHS and VA are supposed to come up with ways to monitor the spending so that we might know what the effect is, is that correct?

Dr. GARTHWAITE. Correct.

Dr. BERENSON. Yes. That is right, and that is where we will take advantage of what we are learning with the DOD subvention, about the need to have the accounting systems in place. But that is absolutely right.

Mr. MCCRERY. Well, what happens if the Secretaries conclude that the program or the demonstration has caused Medicare spending to increase?

Dr. GARTHWAITE. There is a cap. It would come into effect as well. There is a $50 million cap.

Dr. BERENSON. We would also have a very formal reconciliation process that would affect—each year we will find out what the amount is. And there would have to be a reconciliation and a reimbursement.

Mr. MCCRERY. When you say reconciliation, you mean the capitation amount would be adjusted?

Dr. BERENSON. Yes. That is basically right.

Dr. GARTHWAITE. I think, if you really think about this, the veterans who would opt to use this could go somewhere else and have that care as well. We are offering a discounted rate. So it would have to be someone who otherwise would choose not to use it because it wasn't convenient and now the VA made it much more convenient, or some other reason.

Mr. MCCRERY. Most of the proposals that we are dealing with require the VA to develop data systems to measure those Medicare-covered services. Have you got some opinions as to the existing data infrastructure at VA facilities?

Dr. GARTHWAITE. Is that for me?

Mr. MCCRERY. Either.

Dr. GARTHWAITE. Yes. As I mentioned previously, we have been hard at work putting into place what we call a decision support system, which is a computerized tracking system that relates costs and services and individual patients.

So we have that in place in all our medical facilities and by the end of this year should have a full year's worth of data. The next real big issue is getting all of our staff trained to use the data to make decisions. And so that is what we are hard at work doing now.

There are some networks that are very far ahead in this and do it very well. One of the criteria for picking places for the pilots will be that they can demonstrate that they can use the DSS system and that it is fully operational in their facilities.

Dr. BERENSON. Yes, from our point of view, we think these systems are going to be able to accept a capitation payment, account for level of effort, and collect the basic information we need to run something like the Medicare Choice Program, which has encounter data from hospitals which have diagnoses so that we can do the risk adjuster.

But the kind of systems that would be needed for fee-for-service billing for us, we don't think that the VA has capabilities of—right now. We are actually working with Trailblazers, one of the intermediaries from Texas, to try to help the VA get up to speed in claims processing so that they can bill Medigap insurers for services rendered. And we think it will be awhile before they will have

the capabilities, which is another reason why we have concerns about a fee-for-service demonstration. We are working with the VA, so that they will be ready for a capitation-type demonstration.

Mr. MCCRERY. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. Listening to you and the Ranking Member and now the gentleman from Louisiana, maybe it is time to have a further discussion about a single health care financing system.

Chairman THOMAS. The gentleman's time has expired. [Laughter.]

Mr. MCDERMOTT. I'd like to throw a little bit more wider net on this whole question of how you count. Until 1997, the AAPCC, and I am speaking here for Minnesota, Washington, and Oregon. The AAPCC, adjusted average per capita cost, rate was determined on the basis of 5 years' worth of historical per capita Medicare fee-for-service reporting.

Medicare PCC rates also included provisions for medical education payments and for disproportionate share. With the advent of the amendments of 1997 and the balanced budget, we de-linked those AAP rates from local fee-for-service spending and set a minimum 1998 AAPCC floor rate of $367. We also made a number of changes to guarantee the minimum annual rate increases of 2 percent.

We also carved out the medical education component, and unfortunately, these changes do not address what I think is the fundamental inequality in the calculations which Minnesota, Washington, and Oregon face, believing that no good deed goes unpunished.

I am here to raise our cause again, as I did on the Medicare Commission. The trouble with that methodology is that it punishes cost-efficient markets with low AAPCC rates, with lower increases, while higher priced, inefficient markets receive increases well above the average.

In 1997, Group Health of Washington, Seattle, from which a lot of the early data for which—from which people drew the conclusion that managed care was a good place to go. So we are looking at something that has been there for 50 years.

Their average rate increase was 3.8 percent. The national per capita increase was 5.9 percent. So they have been efficient for 50 years and they are punished, not getting the national average when you have these changes.

Counties across the State in my State have had increases as high as 8.9 percent, while for Group Health in King County, it's 3.8 percent. Currently, every county in Washington State is below the national average. King County is 8 percent, the national average. And the Medicare beneficiaries who are eligible for both Medicare and military Medicare coverage sometimes receive their care at military facilities. We have a number of them.

Now that Madigan has been selected as a Medicare subvention demonstration, this will occur even more often than in the past. And to simplify the AAPCC calculation for all fee-for-service costs

of a given county are divided by the Medicare beneficiaries in that county.

You take the cost, you take how many beneficiaries you are going to divide into it, and that is how you come up with it. It is a pretty simple—about a fourth grade division problem.

The computation of that AAPCC includes all Medicare beneficiaries in the denominator. Everybody who is over 65 gets counted. However, since the facilities provide care to military-eligible beneficiaries, they do not report Medicare costs to HCFA. The numerator, that is the amount that is spent, excludes any cost Medicare beneficiaries receive in those facilities.

And this results in an understatement of the AAPCC rates wherever there are military health care facilities. States and counties with significant military medical presence receive disproportionally low rates due to the methodological error in my view. While the national average AAPCC understatement is 3 percent, in King County, it is 4.3 percent, and in Pierce County, which is Takoma, where Madigan is, 2.6 percent.

Now, I would like to know what the administration's views are about revising that methodology, both for Medicare beneficiaries and the cost for all the Medicare services, including those that receive fee-for-service at the military facilities in that calculation.

We hear all this talk about HMOs backing out because they are not getting enough. We hear that they are paid 6 percent too much. And there is all this stuff. But I know what the costs are that you don't cover in my State.

I would like to hear how you are going to deal with this. Or do you intend to?

Dr. BERENSON. Specifically, in the demo or more generally?

Mr. MCDERMOTT. More generally.

Dr. BERENSON. More generally——

Mr. MCDERMOTT. The demo is going to be just another reflection of the problem.

Dr. BERENSON. Yes. Well, and more generally, I guess the President's proposal has a new approach to competitive pricing amongst the plans in which there will be adjustments for the cost, and that really should take into the kind of factor you are raising. In fact, this is relevant to the discussion we had earlier in not really knowing whether we are double paying or whether we are underpaying because of underreporting into the county rates that we are paying.

I guess what I would say is that this is a real issue. The President's got a new proposal on the table this year for the Medicare+Choice plans for counties that have been getting lower increases because they have been efficient. In fact, it is going the other way. The blends in the BBA finally kicked in this year. So many of the counties that you have referred to are in fact getting much higher rate increases than the 2 percent, which the high-payment counties get.

It may not have been soon enough for a number of the HMOs who are announcing today whether they are staying in or not. It is unfortunate that it took to the third year of the blend for it to begin to have an impact. It is a very complicated issue, but I think we now need to look at the new proposal from the President to see if we can solve it in that context.

Mr. MCDERMOTT. I think that you point out the real problem, is that today is D–Day. All the HMOs announce today whether they are going to participate or not. And my reading from our area has got a lot of people pulling out.

They simply can't do it under the capitation rate that has been given to the northwest. And that, as I say, good deeds go punished. In this case, while we continue to put money out in other places, which may or may not have needs that they can justify, we actually can show that our costs are not being paid.

I think it is going to be a big problem. If you don't deal with this—this would give us a little bit more, or a little bit more recognition of what is going on.

Dr. BERENSON. Well, again, for this year, because the blend kicked in really at the third year of the 5-year transition, there are some counties getting as much as 12 or 14 percent. One county is actually getting an 18-percent increase for next year's rates. Again, they are starting off of a low base, and it may not be fast enough for some of the plans.

And I agree with you; it looks like there are going to be significant numbers of pullouts. And it looks like they will be occurring in the those counties that are not going to be in the high-payment counties as far as we can tell. That is a real problem.

Mr. MCDERMOTT. I think, Mr. Chairman, we need really to look at this issue because it would be unfair to say that the Medicare+Choice Program isn't working if we have these kind of methodological things that are built in. And I think you and I and everybody wants the Medicare system to function efficiently, and I think we need to look at some of the wrinkles in it that we may or may not have created—not intentionally, perhaps, but we just didn't know what the consequences would be.

Thank you.

Chairman THOMAS. The gentleman's points, I think, are very well taken. Unfortunately, when you run a bureaucratic structure with administered prices, you only get it right by accident. And clearly, in your area, it hasn't been done correctly.

The idea that somehow under that government structure, you are now going to create a competitive model in which the government defines what a competitive price is, also in my opinion, does not get to the heart of the problem.

The premium support model that the Medicare Commission offered was an integrated plan in which the real labor costs and medical utilization costs were incorporated in the price negotiated between plans, not the government with its arbitrarily drawn number and a plan, which is the reason for a number of plans dropping, but between plans on the real cost of offering the health care benefits would produce not only a product that would make that managed care more available in more areas of the country but, according to the actuaries, over the long haul, because of the competitive pricing model of the premium support and the ability for beneficiaries to choose a price in which there would be no out-of-pocket cost to them in a particular area, would wind up also with a savings to the system.

That, in part, as a public service announcement in opposition to the gentleman's single-payer system.

Mr. MCDERMOTT. Well, I tried, you know, not to get into going someplace you didn't want to go.

Chairman THOMAS. Nor did I, because I do want to reinforce the gentleman's position because this is exactly the problem with the current Medicare+Choice situation, compounded by an area that has had a history of HMO, compounded by significant military presence. In other words, the government is now paying twice, and they aren't even being counted once, which is the real problem with the way in which the structure is currently arranged.

If, in fact, we could resolve the HMO–VA overlap payment problem, I think the first thing we ought to do with the money is direct it to those areas that have been denied because the money was counted twice and was not credited once. That would be an immediate corrective factor. For example, a 22-percent understatement is unfortunately typical of government, but absolutely unacceptable.

Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Well, Mr. Chairman, the solution, certainly, it is not just Washington State and Oregon that's been so negatively impacted by the AAPCC formula, but also the third State which the gentleman mentioned, Minnesota, my own State.

Senator Durenberger, who served with such distinction in the other body for so long and was truly expert on health care—still is expert on health care—used to say, and it is still literally true, that a Medicare beneficiary can receive 2½ Medicare surgeries at the Mayo Clinic for every one in Dade County, Florida. That is just crazy. And the formula has been an unmitigated disaster, not for Washington State, Oregon, but also for Minnesota.

Today, Mr. Chairman, Medica in Minnesota pulled out of this market. Several months ago, Blue Cross pulled out of this market. We are headed for an unmitigated disaster if we don't take the admonition of the Chairman and make some fundamental reforms, and I hope that we can address this problem sooner, rather than later, because too many—the health care of too many people is at stake. And we don't want our veterans to be similarly impacted.

Thank you, Mr. Chair.

Chairman THOMAS. Any additional Members wish to inquire? The gentlewoman from Florida.

Mrs. THURMAN. Mr. Chairman, I want to get a little bit of feeling—I have two VA facilities in the district, one in Lake City and one in Gainesville.

Chairman THOMAS. Would the gentlewoman indicate whether they are VA hospitals or——

Mrs. THURMAN. They are hospitals.

Chairman THOMAS. The hospitals, not outpatient clinics?

Mrs. THURMAN. They are hospitals. Then I do have, though, several outpatient clinics as well, some of which have just come online, others have been established for a very long period of time.

But one of the things that I am hearing from veterans in the district, and first of all, let me compliment you; I don't know of another program that has worked as well as our outpatient. And the biggest problem is they are growing too quickly and we don't have doctors enough to take care of the people we have. And it has been successful; it's a good thing.

But where my concern lies, particularly as I know we are increasing in the VA patients, this personnel, we are hearing an awful lot of complaints about being understaffed. Because we have opened up ambulatory centers, we are not getting people to come from one area of the country down to another.

Can you shed some light on that for us? And is there anything we can do to help in this? I know we closed some beds, but personnel are not getting to those places that are opening and we have a larger caseload, which was part of what we were doing with the changes.

Dr. GARTHWAITE. You ask a very complex question, or at least the answer is complex. There are issues in moving money as we have changed the way we deliver care, moving personnel and money. When you go from inpatient to outpatient, you have to take inpatient-trained nurses and get them trained for outpatient. And if you go from a central location, a large hospital in one place, and try to go out in the community, then you have to either reduce personnel in one area and then add those resources back in another area.

We have had some budgetary uncertainties with regard to next year's budget impacts, with regard to inflation. There are some specific issues in Florida which we have just discussed and have a recommendation to add some resources back to Florida. We are working that through the department based on hurricane and some other formula adjustments.

So I think, for any given situation, it might be hard to dissect out which specific thing was happening. There are also issues across the country, which are local with regard to recruitment of specific types of personnel.

So, in many areas of the country it is hard to find an orthopedic surgeon, it may be hard to find an occupational therapist in another area. And so, it is a combination of those factors, I believe.

Mrs. THURMAN. If we do Medicare subvention, is it going to impact us even more? And are we looking at this as any plan that we are putting together because it is wonderful to be able to expand, but it is a whole other thing to be able to provide the service.

Dr. GARTHWAITE. Correct. Theoretically, we would be reimbursed in proportion to the amount of service that we provided. The challenge for us managerially would be any lag in ramping up capability if that were to be the case.

The pilots are limited enough; it shouldn't be a problem, because I think there is always a little buffering capacity in any large system. But that would be something that we hoped to learn from the pilots and to guard against——

Dr. BERENSON. Yes. I was just going to say, we have in mind about eight sites.

Dr. GARTHWAITE. Right.

Dr. BERENSON. And so I think we would pick some places that have or are in a better situation and more likely to succeed initially.

Mrs. THURMAN. Let me ask one other question. And this is another issue, and it may be taken care of because of some of the expansion. And I am not sure this is true. But the Medicare sub-

vention would not go for veterans that are disabled and service connected.

Dr. GARTHWAITE. Right.

Mrs. THURMAN. So, in some States, where there is a larger population of those veterans being served, which in fact Florida is, and we have looked at those numbers, and yet is still serving thousands of veterans—we have a huge veteran population, as you well know. So when we talk about the dollars from Medicare that would help us with this issue with people, but at the same time there will be hospitals in this country that will not get the same dollars because they won't be able to tap in to Medicare because they are serving many of these people but they are going to be opening up for some other areas.

To keep in mind that it is a huge—and even our Veterans Affairs Committee in Florida has talked about this but there really has not been much or anything significantly done to help us understand and what potentially is going to happen there.

Maybe more of a statement than a comment.

Chairman THOMAS. No, but I tell the gentlewoman that it goes directly to the heart of a significant portion of the controversy in that, with the historical mission of veterans hospitals having been geriatrics, and that they have been centers of excellence in dealing with burns, paralysis, combat-related shock and the fatigue aspects, even substance abuse in a combat-related situation. And so, if in fact, we are going to maintain a separate system in which we are now funding $18 billion a year, the concern would be that if your primary focus is going to be a fee-for-service to these higher income, nonservice-related-disabilities veterans for Medicare purposes, it is clear that we will have to change many of the fundamental medical directions of the veterans to be able to really adequately provide the service the folks are looking for—when, in fact, a lot of Medicare-eligible veterans are just looking for places just to fill their prescription drugs and get outpatient services more along the geriatric line than they are along the veterans line.

That is why a number of us have real concerns about the thrust the VA is taking now. It looks like it is simply going for the bucks instead of meeting what had been a historical commitment by a Veterans Administration for America's veterans.

Mrs. THURMAN. Mr. Chairman, to get to the point of the drug issue, and I do believe that they are looking, because as almost all older Americans are looking for a place to buy drugs at a lower cost——

Chairman THOMAS. No. Actually, I meant substance abuse, but——

Mrs. THURMAN. Oh, OK. I thought you meant pharmaceuticals.

Chairman THOMAS. No. I meant substance abuse.

Mrs. THURMAN. OK. Thank you for clearing that up.

Chairman THOMAS. In fact, we ought to just talk about drugs and we really ought to talk about prescription drugs, although there——

Mrs. THURMAN. Well, if you would like to talk about prescription drugs, we have a great DOD that we are hoping will implement something for mail-order across the country, particularly for those

veterans who are not around those VA hospitals and can't get their——

Chairman THOMAS. Well, there are a number of initiatives that, unfortunately, may not move forward with the departure of Dr. Kizer, which is too bad.

Now, a final question before we move to the other panel, unless any other Member has an inquiry: Dr. Garthwaite, notwithstanding your testimony, which is standard testimony that this will save money, everybody else tells us, CBO included, that we have got to include $300 to $400 million for a 5-year demonstration. I think that fairly up front demonstration of the fact that nobody else believes it is going to save money. And you don't have the ability to determine where and how you are spending your money now, but you remain adamant that it is going to save money.

I am more than willing to give you the parting shot on how you resolve these apparent discrepancies.

Dr. GARTHWAITE. I would like to, first, just say that we are saddened by Dr. Kizer's departure, as you have expressed, and would note that I worked side-by-side with him for the last 5 years and that we have carefully attempted to recruit people who had a common vision with Dr. Kizer's vision. And we believe that to the greatest extent possible, we will be continuing on in the same direction that Dr. Kizer set out for the department.

Chairman THOMAS. I just tell, Doctor, that I am tempted to quote a former vice presidential debate phrase about the fact that I know Dr. Kizer, and so forth, and so forth.

Dr. GARTHWAITE. I didn't suggest that I was Dr. Kizer, but I do suggest that the team that Dr. Kizer helped put together was recruited based on a common set of shared principles and hopes for the future.

I would just say that we have capped the amount of money that can move. We have really not added a new entitlement to these individuals; we have just added another place they can take that. If it is more convenient to their home, I suppose people who otherwise weren't making use of their Medicare would now make use of their Medicare. But, I think we need to do the pilot experiment to find out, and I think we have set up mechanisms by which we will be able to measure whether or not that is true.

Chairman THOMAS. Well, and, of course, that is the proof of the pudding. I want to thank both of you very much.

And Dr. Berenson, as we move forward, especially with the provisions that the Senate has now included in the bill, we are going to need a lot of help to make sure that what the House and the Senate arrives at is in fact a sound proposal and it can be tested.

Thank you both very much.

And the next panel, once again a return engagement, for our friend, Dr. Bill Scanlon, is the Director of the Health Financing Systems at the General Accounting Office, and I believe as a resource, Mr. Backhus, who is the Director of the Veterans Affairs and Military Health portion of the U.S. General Accounting Office.

Dr. Scanlon, your written testimony will be made a part of the record. You can address us in any way you see fit in the time that you have.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; AND STEPHEN P. BACKHUS, DIRECTOR, VETERANS AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman, and Members of the Subcommittee.

We have actually submitted a joint statement, the two of us, and I would like to summarize it for you this morning. Stephen Backhus is the director of GAO's Veterans Affairs and Military health care area. And staff from both his area and my area are engaged in the evaluation of the DOD subvention demonstration as is mandated by the Congress in the Balanced Budget Act.

Subvention, as you have indicated, has the opportunity to provide an alternative for delivering accessible and quality care to certain Medicare-eligible veterans and military retirees, hopefully, without increasing the cost of services for VA or DOD or to Medicare.

It would allow both of those departments to supplement some appropriated funds with Medicare payments, and Medicare may gain if it is able to pay DOD and VA less than it would pay private providers and as long as Medicare is not paying for services that VA and DOD previously would have covered.

These favorable outcomes are not guaranteed. There have, as we have heard this morning, been various proposals made for VA subvention. And in our written statement, what we have done is summarize them for you. What I would like to do today is focus on some of the lessons for the proposed VA subvention that have emerged from the implementation of the DOD subvention.

First of all, the complexity of establishing a Medicare managed-care organization strongly suggests that sufficient lead time be provided to implement a VA demonstration. It took 17 months for all the sites in the DOD demonstration subvention to become operational, despite considerable efforts by HCFA and DOD to expedite the process, and despite DOD's experience with managed care gained from its TRICARE Program. It would be reasonable, therefore, to allow 12 to 18 months to start a VA subvention demonstration, especially since VA, unlike DOD, does not have an established relationship with HMOs that can take on important tasks.

Second, with subvention, adequate payment methods are needed to protect the Medicare Trust Funds. Under the rules established for the DOD demonstration, Medicare does not pay DOD until it has provided as much care as it had historically for Medicare-eligible retirees. The reason for this is to ensure that DOD wasn't paid twice for the same care, once from its appropriated funds and again by Medicare.

While proposals for VA subvention include a similar requirement, the DOD experience suggests that operationalizing this concept involves considerable challenges. Most important is likely the development of an accurate estimate of VA's level of effort, which is needed to reduce the chance that Medicare would overpay or underpay.

Third are data systems. They are critical to both the determination of payments and the management of programs. A prompt and thorough review of them with an eye to the needs of subvention would be immediately beneficial. DOD's data systems proved to be very problematic in calculating DOD's level of effort and may further hinder the demonstration sites' ability to manage care delivery.

In addition, a number of issues are unique to the VA. VA needs to determine how to make subvention attractive to sufficient numbers of eligible veterans. At this point, all veterans can enroll to receive any of VA's comprehensive benefits, and they still remain eligible to use any Medicare-covered services available from private providers.

These veterans may see no advantages to being locked into a subvention managed-care plan and having to forego using other providers for some Medicare services. VA also needs to take steps to serve subvention enrollees without unduly crowding out other higher priorty veterans.

In conclusion, subvention holds significant potential for giving veterans an additional option for health care coverage, for giving VA some additional funds, and possible for saving Medicare money.

However, these outcomes are uncertain. The DOD's experience indicates that there are challenges to overcome to assure subvention is a success. Adequate planning and a soundly conceived design, sufficient, accurate and timely information, as well as adequate and appropriate incentives are all key elements. VA would increase its chances of successfully achieving subvention's goals by taking advantage of DOD's experience.

This concludes our statement. We would be happy to answer any questions you may have.

[The prepared statement and attachments follow:]

Statement of William J. Scanlon, Ph.D., Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, U.S. General Accounting Office; and Stephen P. Backhus, Director, Veterans Affairs and Military Health Care Issues, Health, Education, and Human Services Division

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you review proposals for a Medicare subvention demonstration for the Department of Veterans Affairs (VA). The stated goal of VA subvention is to provide an alternative for delivering accessible and quality care to certain Medicare-eligible veterans, without increasing the cost to Medicare or to VA.

Several VA subvention proposals resemble in many respects the current Department of Defense (DOD) demonstration. Medicare-eligible military retirees who enroll in the DOD subvention program are able to get Medicare-covered services from DOD. Similar proposals would allow certain Medicare-eligible veterans to use their Medicare benefits at VA facilities. Subvention could allow VA, like DOD, to supplement its funds with Medicare payments. In principle, by paying VA a discounted rate, the Medicare program might save money, so long as it does not pay for services that VA previously would have covered.

Although the DOD and the proposed VA demonstrations are relatively small, full-scale subvention programs could significantly affect the Medicare trust funds and the costs of VA and DOD. The 3-year DOD demonstration involves about 30,000 enrolled retirees and limits Medicare payments to DOD to, at most, $65 million a year. By contrast, a nationwide DOD subvention program could potentially involve substantially more in Medicare payments. In VA, the potential size of a nationwide program may be even greater. There are about 9 million veterans aged 65 and older, and nearly all of them are covered by Medicare.

Favorable outcomes for Medicare, VA, and DOD, as well as military retirees and veterans[1] are not, however, guaranteed. For DOD subvention, the Balanced Budget Act of 1997 (BBA) authorized a large-scale, 3-year demonstration and directed GAO to evaluate the demonstration's effects on access to care, quality, and the cost to DOD and to Medicare. We have recently reported on data quality and payment issues affecting the DOD demonstration and the potential for Medicare overpayments.[2] We will be providing you with further interim reports on aspects of the demonstration. Our final results will not, however, be available until several months after the demonstration ends in December 2000.

Our testimony today focuses on a possible VA subvention demonstration and on issues that VA subvention raises. Specifically, we will compare the 1998 House Ways and Means Committee bill on VA subvention with the Senate Finance Committee proposal and discuss the unique characteristics of VA health care that bear on subvention. We will also discuss lessons learned from the design and early implementation of the DOD demonstration that may be relevant to the proposed VA demonstration.

In summary, the 1998 House Ways and Means bill and the current Senate Finance proposal are similar in that both provide for time-limited subvention demonstrations in which Medicare pays VA at a discounted rate to care for veterans who are aged 65 and older and who are covered by Medicare. However, there are also significant differences between the two proposals. For example, the Ways and Means bill includes a permanent program for veterans in rural areas who have low incomes or severe service-connected disabilities, while the Finance proposal would establish two demonstration models—fee-for-service and coordinated (managed) care—for lower priority veterans. Under any proposal, subvention holds several challenges for VA. It will be challenged to attract to a subvention coordinated care program veterans who currently enjoy a generous VA benefits package. VA will also need to strengthen its billing systems to operate a fee-for-service model and will need to ensure that veterans' access to services—whether or not they are in the demonstration—is not reduced. Learning from DOD's experience to date, VA will need sufficient time to implement a subvention demonstration—officials at every DOD site told us that establishing the demonstration was more difficult than they had expected. DOD's experience also shows that VA payment methods must be carefully designed and implemented both to protect the Medicare trust funds and to promote cost consciousness and efficiencies at VA demonstration sites. Finally, as DOD's experience underscores, sound data systems are essential for managing and evaluating a subvention demonstration.

BACKGROUND

Medicare

Most military retirees aged 65 and over are eligible for Medicare—a federally financed health insurance program for the elderly, some disabled people, and people with end-stage kidney disease. Medicare covers about 39 million beneficiaries and spends about $212 billion a year. Benefits include hospital, physician, and other services such as home health and limited skilled nursing facility care. The Health Care Financing Administration (HCFA) administers Medicare and regulates participating providers and health plans.

Medicare was originally set up to reimburse private providers on a fee-for-service basis and to allow Medicare beneficiaries to choose their own providers without restriction. A newer option[3] allows Medicare beneficiaries to choose among private, managed care health plans. Currently, 17 percent of beneficiaries use Medicare managed care. In fee-for-service Medicare, beneficiaries must pay a share of the costs for various services. Most Medicare managed care plans have only modest beneficiary cost-sharing, and many offer extra benefits, such as prescription drugs.

VA Health Care

VA has traditionally provided a comprehensive array of health services to veterans with service-connected disabilities or low incomes. Since 1986, VA has also offered health care to higher-income veterans without service-connected disabilities. However, those veterans must make copayments for services. Overall, VA currently

[1] Military retirees are those who have completed a military career and are entitled to retirement pay. Veterans include all who served and who did not receive a dishonorable discharge.

[2] *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustment and Raise Broader Concerns* (GAO/HEHS–99–39, May 29, 1999).

[3] BBA expanded this option to include plans in addition to health maintenance organizations and labeled it "Medicare+Choice."

registers in its health care system over 15 percent of the total veteran population of 25 million, with the remaining veterans receiving their health care through private or employer health plans or other public programs. Many of the veterans that VA serves also get part of their care from other sources, such as DOD, Medicare, and private insurance. The Administration has requested $17.3 billion for VA medical care in fiscal year 2000. To make up the differences between appropriated funds and projected costs, VA estimates that, by fiscal year 2002, it can derive almost 8 percent of the medical care budget from other sources, such as reimbursements from health insurers and, if subvention is enacted, from Medicare.

Since the early 1990s, VA has shifted its focus from inpatient to outpatient care. At the same time, it implemented many of the principles of coordinated—that is, managed—care, emphasizing primary care, although many veterans use VA for only a portion of their care. In 1995, VA accelerated this transformation by realigning its medical centers and outpatient clinics into 22 service delivery networks and empowering these networks to restructure the delivery of health services.

In 1996, the Congress passed the Veterans' Health Care Eligibility Reform Act that established, for the first time, a system to enroll veterans. Enrollment is, in effect, a registration system for veterans who want to receive care. Currently, registration is continuous—a veteran may choose to register at any time and start receiving services—although VA has the authority to limit the enrollment period if it chooses. The law established seven priority groups, with priority group 1 the highest and priority group 7 the lowest. Priority group 1 includes those veterans with the most severe service-connected disabilities; priority group 7 includes veterans whose incomes and assets exceed a specified level and who do not qualify for VA payments for a service-connected disability. Priority group 7 veterans must agree to make copayments for health services.

Each year, VA determines, on the basis of available resources, which priority groups will be eligible for VA care in the coming year. Currently, VA serves all seven priority categories, but in the future, that will not necessarily be true. Veterans in any of the priority groups are eligible for the VA Uniform Benefits Package, a comprehensive array of services ranging from hospital care to home health.

Veterans remain free to get some or all of their care from other private or public sources, including Medicare. VA, on the other hand, is committed to serving all veterans within the priority groups it has designated for that year, although capacity varies by region.

DOD Health Care

DOD received an appropriation for military health care of almost $16 billion in fiscal year 1999. Of that, an estimated $1.2 billion is spent on the 1.3 million Medicare-eligible military retirees. Under its TRICARE program, DOD provides health benefits to active duty military personnel and retirees,[4] but most retirees lose their eligibility for comprehensive, DOD-sponsored health coverage at age 65. DOD delivers most of the health care needed by active duty personnel and military retirees through its military hospitals and clinics. DOD gives priority for care at military facilities to active duty personnel and to dependents of active duty personnel and those retirees under 65 who are enrolled in DOD's managed care program. Retirees who turn 65 and become eligible for Medicare can get military care if space is available (called space-available care) after higher priority beneficiaries are treated.[5] Some military facilities have little or no space-available care.

Since the early 1990s, DOD health care has shifted toward managed care. DOD established its own managed care plan, TRICARE Prime, which uses military providers, supplemented by a network of civilian providers. However, it is not available to retirees aged 65 and over.[6] TRICARE Prime covers services of military physicians as well as civilian network providers by drawing on DOD's appropriated funds and premiums and copayments charged to some enrollees. In TRICARE Prime, DOD generally organizes the delivery of care on managed care principles—for example, an emphasis on a primary care manager for each enrollee. DOD has gained considerable experience with managed care, but it relies heavily on contractors to conduct marketing, build a network of providers, and perform other critical functions.

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[4] We use "retirees" to refer to military retirees, their dependents, and their survivors.

[5] A partial, unofficial exception to this rule occurs at teaching hospitals, where aged retirees with serious, persisting conditions are treated on an ongoing basis, in large measure so that medical residents can be given the clinical experience required.

[6] Active duty members of the armed forces receive their health care through TRICARE Prime. Dependents of active duty military can choose among three DOD-run health plans that include TRICARE Prime. Retirees under 65 can pay a premium and "buy in" to TRICARE Prime.

DOD Subvention Demonstration

BBA established a 3-year demonstration of Medicare subvention, to start on January 1, 1998, and end on December 31, 2000. Within BBA's guidelines, DOD and HCFA negotiated a "memorandum of agreement." The agreement stated the ways in which HCFA would treat DOD like any other Medicare health plan and the ways in which HCFA would treat it differently. The agreement also spelled out the benefits package and the rules for Medicare's payments to DOD. After DOD and HCFA signed the agreement, they selected six demonstration sites. DOD estimated that it would be able to serve nearly 30,000 of the approximately 125,000 people eligible for both Medicare and military health benefits in these areas.

The subvention demonstration made DOD responsible for creating a DOD-run Medicare managed care organization for elderly retirees. This pilot health plan, which DOD named Senior Prime, is built on DOD's existing managed care model. By enrolling in Senior Prime, Medicare-eligible military retirees obtain priority for services at military facilities—an advantage compared to nonenrollees. Senior Prime's benefit package is "Medicare-plus"—the full Medicare benefits package supplemented by some other benefits, notably prescription drugs.

BBA provides the basic rules by which, under the demonstration, Medicare pays DOD. First, Medicare is to pay DOD the Medicare managed care rate, less several adjustments and a 5-percent discount for each enrollee. Second, in order to receive Medicare payments, DOD must at least match its baseline costs, or level of effort—that is, devote at least the same resources as it did in the recent past to providing care to retirees aged 65 and older. The memorandum of agreement translates these guidelines into a complex payment system. For example, it allows any demonstration site to earn monthly interim payments if its Senior Prime enrollment exceeds a threshold derived from the baseline level of effort. But at the end of the year, DOD can only retain a portion of these payments if that year's costs for the six sites together exceed the baseline level of effort.[7]

PROPOSALS FOR VA DEMONSTRATION DIFFER BUT SHARE KEY FEATURES

Although several proposals for a VA Medicare subvention have been developed recently, our analysis focuses on two: a House Ways and Means Committee bill (H.R. 3828) passed by the House in 1998 and a proposal adopted by the Senate Finance Committee on June 24, 1999. While similar in key respects, the two proposals also differ in several significant ways, including whether a VA subvention would include a fee-for-service model and whether a permanent program—in addition to a demonstration targeting certain veterans—would be established in rural areas for higher priority veterans. The two proposals share certain features, including a managed care model (which the Finance Committee calls "coordinated care") for at least part of the subvention proposal, a demonstration targeting lowest priority veterans, and a cap on annual Medicare payments to VA under the demonstration.

H.R. 3828 (105th Congress)

The House bill is distinctive in authorizing both a permanent subvention program and a demonstration project:

— The permanent subvention program would follow a managed care (or coordinated care) model. It would target VA's higher priority level veterans (for example, people with severe service-related disabilities or low incomes) in rural areas and could be continued indefinitely. It would begin with up to three sites, but more sites could be added after 2003. VA would have to maintain its level of effort—its historical resource commitment—to the targeted group of veterans in the sites. Medicare payments would be capped at $50 million the first year, $75 million the second year, and $100 million in subsequent years. No cap would apply if the program were expanded to more sites, subject to certification by the Department of Health and Human Services' (HHS) Inspector General (IG) that VA could measure its costs in a reasonably reliable and accurate manner.

— By contrast, the demonstration would be limited to veterans in the lowest priority level for VA care at no more than three sites and would deliver services for not more than 3 years. One site would have to be an area previously served by a military health facility shut down in the military base closing process, known as the BRAC (Base Realignment and Closure) process. Unlike the permanent program, no rural sites are required. Medicare payments to VA under the demonstration would be capped at $50 million annually. The bill would allow requiring veterans to pay enrollment fees and copayments that could vary with income.

[7] These issues are discussed in greater detail in GAO/HEHS–99–39.

For both the demonstration and the permanent program, the House bill emphasizes that, if practicable, VA should use its outpatient clinics. However, VA could still contract with private providers and health plans to supply services as needed.

The Senate Finance Proposal

The scope of the Finance Committee proposal[8] is in some respects narrower—its demonstration is limited to the lowest priority veterans (priority group 7, higher income veterans who mostly lack a service-connected disability). In other respects, it is broader—authorizing a test of two subvention models. The proposal would require VA to establish, first, a coordinated care model of subvention and, a year later, a fee-for-service model. It would authorize a VA subvention demonstration in, at most, eight sites but would require equal numbers of sites for the two models. The proposal would allow up to a year for implementing each model, which would operate for up to 3 years after enrollment started.

Medicare's rules for paying VA would resemble those in the DOD subvention demonstration: To guard against the same VA care being paid for by both VA appropriated funds and Medicare, the proposal would require VA to demonstrate maintenance of its effort on behalf of the demonstration population. HCFA would pay VA for the care of veterans in the demonstration only after VA exceeded its historical spending, or level of effort, for higher-income veterans.

Common Features of the Two Proposed Demonstrations

The House bill and Senate proposal share certain common elements. In each, a VA subvention demonstration would include a managed care (or coordinated care) model and serve certain higher-income[9] veterans (effectively, priority group 7) who are Medicare beneficiaries

—for a limited time period—3 years,

—in a limited number of locations, and

—in compliance with Medicare rules that HCFA applies to the private sector (although HCFA could waive rules that were inappropriate for VA).

Regarding Medicare payments to VA,

—HCFA would pay VA at 95 percent of the applicable Medicare rate paid to private providers or health plans—less certain exclusions, such as payments for disproportionate share hospitals and graduate medical education;

—HCFA payments to VA would be limited to a predetermined annual amount, such as $50 million; and

—VA must meet its previous level of effort in providing services to Medicare-eligible veterans.

(For a more extensive comparison of the two proposals, see app. I.)

VA DEMONSTRATION WOULD FACE CHALLENGES CONCERNING PARTICIPATION, BILLING, AND ACCESS

A proposed VA demonstration holds several challenges. First, veterans may see no advantage in enrolling in a subvention managed care plan because everyone eligible for the demonstration currently has both VA and Medicare benefits. Second, VA's past difficulties in billing insurance companies suggest that VA may have difficulty billing Medicare for services provided to veterans. Finally, if subvention enrollees prove to be heavy users of VA services, they may crowd out or limit the access of other, higher priority veterans.

For VA, an important issue to consider is whether veterans would enroll in a subvention managed care plan that would not give them significantly more services than they currently receive from VA and that would restrict their freedom to use other providers. Priority group 7 veterans-the only ones eligible for a subvention demonstration-can now obtain all services in VA's Uniform Benefits Package (although not always in a timely manner). Like Medicare, VA benefits cover a broad range, including inpatient and ambulatory medical and surgical care, certain plastic surgery, and durable medical equipment. VA benefits are particularly strong, compared to Medicare, in mental health care, comprehensive rehabilitative care and services, preventive services, and respite care. The VA benefit also—unlike Medicare—covers drugs. Copayments are generally no greater than under Medicare fee-for-service. Additionally, veterans who are eligible for Medicare can also get care

[8] The text of this bill is not yet available. Our description is based on a summary, prepared by Committee staff for the markup on June 24, 1999, of the proposal contained in the Chairman's Mark. The Committee adopted the proposal.

[9] Those who exceed VA's income thresholds for cash benefits. For example, the current threshold for a single veteran without dependents is $22,351.

from non-VA providers—either under fee-for-service or through a managed care plan—whereas, under subvention, members would be locked out of other Medicare plans and providers. If it needed to make subvention benefits more attractive, VA could either reduce copayments or increase benefits, but these actions would increase VA's costs.

In the future, however, VA benefits, as well as the number of priority groups served, may be reduced. Paradoxically, the less generous the VA package for all veterans, the greater their incentive to participate in the demonstration because that would be the only way they could obtain the full range of VA care. VA is authorized to reduce its Uniform Benefits Package and stop serving lower priority veterans, including priority group 7. VA officials tell us that, due to resource constraints, VA may not serve priority group 7 veterans in the future and may reduce the benefits covered under the benefits package. If this happens, these priority group 7 veterans could only get VA services through a subvention demonstration and, hence, would probably be more likely to join the VA Medicare subvention demonstration.[10] Furthermore, some VA officials have suggested to us that, to give priority group 7 veterans a reason to enroll, it may be necessary to exclude them from VA services—except through the demonstration.

Current proposals for a VA subvention demonstration, such as the Senate Finance Committee's, permit both managed care and fee-for-service sites. Of the two, fee-for-service appears to be easier to implement because it only requires VA to submit claims for covered services to HCFA for payment. It does not require the veteran to join a VA-operated managed care plan and forego access to other providers. However, in the past, VA has had difficulty in collecting from insurance companies because its bills have not had enough detail (for example, diagnosis, service, procedure, and individually identified provider).[11] While VA is moving toward a system that will more closely approximate private sector billing procedures, its success remains to be seen.

The greatest concern in a VA subvention program—either coordinated care or fee-for-service—is that subvention enrollees could consume so many services that veterans in higher priority groups would be crowded out or their access to care restricted. This concern is particularly great in the case of VA, both because of its constrained resources and its current policy of not denying care to any veterans. VA's budget has been essentially flat for the last 3 years, and the President's budget proposes the same amount for medical care in fiscal year 2000 as was appropriated to VA for fiscal year 1999. However, VA has not only restructured and moved resources from inpatient to outpatient care; it also increased the number of veterans served and is considering several expensive new initiatives, such as a hepatitis C program. One result has been pressure on resources and, in some areas, increased waiting times for appointments. Furthermore, according to its policy, VA does not deny care to any veteran, although veterans may have to wait longer to obtain the care. In the short term, if subvention absorbed more resources than a medical facility had available, waiting times for appointments would probably increase or care could be limited to certain facilities, which might be inconvenient for some veterans. It is unclear how much of an impact increases in waiting times or other types of decreased access would have on enrollees in the demonstration. VA would probably try to ensure that access was maintained for demonstration participants, since their continued participation increases VA resources.

PROPOSED VA DEMONSTRATION CAN BENEFIT FROM DOD EXPERIENCE

Taking account of DOD's experience in establishing a subvention demonstration could strengthen proposals for a VA demonstration. In particular, DOD experience shows that implementation is difficult and that enough time should be allowed to undertake the numerous steps needed to get a demonstration started. Furthermore, an adequate payment method is essential to protect the Medicare trust funds, and payment rules need to be as simple and straightforward as possible. Finally, accurate and reliable data systems are needed to manage demonstration costs and health care effectively.

A detailed discussion of these issues is in appendix II. The following summarizes the main lessons from DOD's experience.

—Time needed for implementation should be recognized. Officials at every DOD site told us that establishing a Medicare managed care organization was more dif-

[10] Since many veterans obtain only part of their care from VA, this still might not be sufficient incentive.

[11] See *VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult* (GAO/HEHS–98–4, Oct. 17, 1997).

ficult and required more effort than they had expected. Months into the implementation, they continue to encounter new issues. Even though the sites took 13 to 17 months after the legislation was passed to establish Senior Prime, hindsight suggests that the goals to get it running earlier were unrealistic. If a VA demonstration is authorized, it should have 12 to 18 months to implement its plans for the demonstration; both VA headquarters and sites would need that much time.[12]

—Payment methods need careful design and oversight. In any demonstration of Medicare subvention, adequate payment methods are needed to protect the Medicare trust funds. The DOD demonstration stipulated that Medicare would not pay DOD unless DOD had provided its Medicare-eligible retirees an amount of care exceeding its historical level of effort for these retirees. Under a VA demonstration, a similar requirement would be desirable. An accurate estimate of VA's baseline costs would reduce the chance that Medicare would overpay or underpay VA under a subvention demonstration.[13]

DOD and HCFA also encountered difficulties due to (1) the complexity of the Medicare payment rules for subvention, (2) the definition and measurement of baseline costs, and (3) ambiguity about what sites could earn and whether earnings would be distributed to the sites. As a result of these factors, many DOD site managers and physicians have largely disregarded the uncertain gain in financial resources from possible Medicare payments and have focused primarily on implementation and patient care issues. Consequently, the DOD demonstration may not produce the full savings and efficiencies that are expected from managed care.

DOD's experience can be used in designing a possible VA demonstration. First, payment rules should give VA and its sites greater certainty about their earnings. Second, if a VA demonstration had a level-of-effort requirement, the baseline costs should be for a period as close as possible to the start of the demonstration. This would minimize problems of comparing current and baseline costs. It would also facilitate audits of the data. Third, sites should be informed in advance what proportion (if any) of their Medicare earnings would be retained centrally or regionally.[14]

—Accuracy of data systems relies on agency commitment. DOD's experience shows that data systems are a point of vulnerability for a successful and credible program. Inadequate data quality can weaken the management of a demonstration and raise questions about reports of its favorable results. The extent to which data quality would pose an obstacle to a VA demonstration depends in part on how the payment rules are specified. Good data, consistent across sites, would also be needed to manage and evaluate the demonstration. Data quality problems would probably vary by site, with some sites having better data than others. The types of data systems needed would depend in part on the subvention model that is selected. For example, in a fee-for-service model, billing systems are critical. In general, solving data quality problems requires commitment and follow-through of agency management.

In addition, DOD experience suggests that veterans in a potential VA subvention demonstration would benefit if VA were to develop a strategy to inform and assist them with their options after the demonstration ends. Furthermore, as Medicare enrollment in managed care plans is shifting to an annual open season, coordinating enrollment in and termination of the demonstration with Medicare's open season would help demonstration participants.

CONCLUDING OBSERVATIONS

Subvention holds significant potential for giving veterans an additional option for health care coverage, for saving Medicare money, and for giving VA additional funds. However, these favorable outcomes are not guaranteed. We have identified several challenges, based on the particular characteristics of VA as well as the experience of DOD subvention. If a VA subvention demonstration were designed to take account of the issues we have raised, its chance for success would be greater. In particular, for a managed (or coordinated) care demonstration, veterans need to have sufficient incentives—compared to the standard VA benefits—to enroll. For a fee-for-service demonstration, VA needs adequate billing systems to ensure that it receives the money it earns. And, as with any demonstration, it will be important to

[12] The Finance Committee proposal provides a year for start-up and initial implementation of the demonstration. It also would stagger the start of the two models: the fee-for-service model would start a year after the coordinated care model.

[13] The payment rules in the DOD demonstration are, at least in principle, adequate for the short term but would be undesirable for a longer-term program. A different payment method, with more understandable rules and viable for the longer term, would be need to be developed if the DOD demonstration were extended.

[14] VA calls the regional level a Veterans Integrated Service Network, or VISN.

protect both participants' and other veterans' access to care. DOD's experience with subvention to date shows the importance of sound data systems that consistently and accurately capture financial and workload data. It also underscores the importance of straightforward and easy-to-understand payment rules and a clearly defined level of effort that creates a level playing field for both VA and Medicare.

Mr. Chairman, this concludes our prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512–7114 or Stephen P. Backhus at (202) 512–7101. Key contributors to this testimony include Gail MacColl, Jonathan Ratner, Dayna Shah, and Phyllis Thorburn.

Appendix I

COMPARISON OF 1998 WAYS AND MEANS BILL AND 1999 SENATE FINANCE PROPOSAL ON VA SUBVENTION

Table I.1.—H.R. 3828 (105th Congress) and Senate Finance Proposal Summary

H.R. 3828 (105th Congress)[1]	Senate Finance proposal summary[2]
What would be authorized and who is targeted:	
—A demonstration project under which Medicare would reimburse VA for care provided to veterans enrolled in Medicare parts A and B who have no service-connected disability and who do not meet VA's low-income threshold.	A demonstration project under which Medicare would reimburse VA for care provided to veterans enrolled in Medicare parts A and B who have no compensable service-connected disability and do not meet VA's low-income threshold
—A program under which Medicare would reimburse VA for care provided to veterans enrolled in Medicare parts A and B who have service-connected disabilities or who are low-income and who live far from a VA medical center.	
How would health care be delivered:	
To the extent practicable, VA would use its outpatient clinics to provide services under the program. VA may enter into contracts and arrangements with entities such as private practitioners, providers, preferred provider organizations, and health care plans to provide health care under the program or demonstration project.	Fee-for-service and coordinated care model consistent with Medicare+Choice requirements
How many health care delivery sites:	
—Up to three demonstration project sites, at least one of which must encompass the area served by a military medical facility closed pursuant to a base closure and realignment act.	—Up to 4 coordinated care sites, at least one of which must be operated in a predominantly rural area
—Initially no more than three program sites, but additional sites could be designated starting in 2003.	—Up to four fee-for-service sites, at least one of which must be operated in a predominantly rural area
	An equal number of sites would represent each model
When would demonstration or program begin and end:	
—Demonstration would begin Jan. 1, 1999, and end Dec. 31, 2001.	—Coordinated care model would begin Jan. 1, 2000, and end 3 years after enrollment begins or, if earlier, Dec. 31, 2003
—Program would begin Jan. 1, 2000, and may continue indefinitely.	—Fee-for-service model would start Jan. 1, 2001, and end the earlier of 3 years after first enrollment or Dec. 31, 2004

Table I.1.—H.R. 3828 (105th Congress) and Senate Finance Proposal Summary—Continued

H.R. 3828 (105th Congress)[1]	Senate Finance proposal summary[2]
Would the start of the demonstration or program be contingent on VA meeting certain requirements:	
Yes. HHS' Office of Inspector General (OIG) must certify that VA and HHS have established a data-matching program to identify veterans eligible for Medicare and entitled to VA benefits and have performed such a comparison.	Yes. HHS' OIG must certify VA has (1) cost accounting systems for each demonstration site; (2) reliable, accurate, and consistent data across sites; (3) minimized the risk that VA appropriations will be used for demonstration; (4) the capacity at each site to provide benefits to sufficient numbers of targeted Medicare-eligible veterans; and (5) sufficient safeguards at each site to minimize reduction in quality or access to care to veterans (participating and not participating in demonstration.)
How would an eligible veteran participate:	
Participation in the program or demonstration project is voluntary. Enrollment is implied.	Eligible veterans must enroll in the demonstration. Eligibility must be verified prior to receiving services
How much would Medicare pay to VA:	
95 percent of amount paid to Medicare+Choice organization (excluding payments for medical education and disproportionate share and capital-related payments to hospitals for inpatient services).	—Under the coordinated care model, 95 percent of amount payable to Medicare+Choice organization —Under fee-for-service, 95 percent of Medicare rate Payments for medical education and disproportionate share excluded from reimbursements; one-third of capital-related costs included
Would there be a cap on Medicare reimbursements:	
Yes: ..... —For demonstration project, not more than $50 million annually for 1999 through 2001. —For program, not more than $50 million for 2000; $75 million for 2001; and $100 million for 2002 and each succeeding year but no cap if program expands to additional sites, subject to HHS' IG certification.	Yes; $50 million for each year of the demonstration
What would veterans be required to pay:	
For the demonstration project, veterans may be required to pay enrollment fees and to make copayments, which can vary based on income. Fees and copayments must be consistent with Medicare+Choice requirements, except as waived by HHS.	(Not specified in the Senate Finance proposal summary.)
Would VA be required to maintain its historical level of health care services to Medicare eligible veterans:	
Requires that VA and HHS agreement describe how maintenance of effort will be implemented in both the demonstration and program. However, only implementation of the program is conditioned on VA reporting to the Congress and GAO on steps taken to prevent reduction in type or amount of health care services provided. An agreement entered into by VA and HHS would determine a base year against which VA must maintain overall the level of effort for services.	Yes. VA expenditures at any site must exceed an established baseline amount before Medicare reimbursement will occur

Table I.1.—H.R. 3828 (105th Congress) and Senate Finance Proposal Summary—Continued

H.R. 3828 (105th Congress)[1]	Senate Finance proposal summary[2]
How would baseline level of effort be calculated:	
VA and HHS would jointly determine a base year. VA would report to the Congress and GAO on its methodology and basis for calculating level of effort.	(Not specified in the Senate Finance proposal summary.)
Would Medicare requirements apply:	
Yes. Both demonstration project and program must meet all requirements of Medicare+Choice plans. (HHS may waive any requirement if waiver reflects VA's status as a federal agency and is necessary to carry out the program or demonstration project.).	Yes. Coordinated care demonstration must provide, at a minimum, Medicare benefits under Medicare+Choice rules and regulations, unless waived by HHS for specific reasons
How would costs to Medicare be monitored:	
GAO would report annually on cost increases to Medicare under demonstration or program. If VA and HHS conclude that demonstration or program has increased Medicare spending, VA must reimburse Medicare and adjust future Medicare payments.	Annual reconciliation process to ensure no increase in costs to Medicare. GAO must report annually on the extent, if any, to which costs to the Medicare program under the demonstration have increased

[1] The provisions of H.R. 3828 were incorporated into H.R. 4567, which passed the House on Oct. 10, 1998.
[2] The text of this bill is not yet available. Our description is based on a summary of a proposal titled *Chairman's Mark: The Medicare Subvention Demonstration for Veterans Act of 1999*, prepared by the staff of the Senate Committee on Finance, June 24, 1999. The Committee adopted the proposal on that date.

Appendix II

EXPERIENCE IMPLEMENTING DOD SUBVENTION DEMONSTRATION

In implementing the subvention demonstration, DOD and HCFA completed numerous and substantial tasks. DOD sites had to gain familiarity with HCFA regulations and processes, prepare HCFA applications, prepare for and host a HCFA site visit to assess compliance with managed care plan requirements, develop and implement an enrollment process, market the program to potential enrollees, establish a provider network (for care that cannot be provided at the military treatment facilities), assign primary care managers to all enrollees, conduct orientation sessions for new enrollees, and begin service. The national HCFA and DOD offices developed a memorandum of agreement, spelling out program guidelines in broad terms. They also developed payment mechanisms, and translated the BBA requirement that DOD maintain its historical level of effort in serving dual eligibles into a reimbursement formula.

HCFA accelerated review procedures and assigned additional staff so that timelines could be met. But these accomplishments were not without difficulties, and several issues remain that are likely to impact the demonstration's results. These include the extent to which payment rules can be made more understandable and workable and the extent to which DOD can operate successfully and efficiently as a Medicare managed care organization.

Implementation Delayed by Several Factors

In view of the steep learning curve that DOD faced—it started without any Medicare experience—it is not surprising that the demonstration did not start on time. BBA was enacted in August 1997 and authorized a demonstration beginning in January 1998. The first site started providing service in September 1998, and all sites were providing service by January 1999. Officials at all DOD sites emphasized to us that the process of establishing a Medicare managed care organization at their facility was far more complex than they had expected. They noted several issues that caused difficulty during this accelerated startup phase, including the following:

—Delayed notification to sites of their selection for the demonstration.

—Difficulties in learning and adapting to HCFA rules, procedures, and terms for managed care organizations. For example, DOD had to significantly rework grievance and appeals procedures to comply with HCFA requirements.

—Difficulties due to shifts in Medicare requirements. All sites started planning as HCFA was developing the new Medicare managed care regulations to replace the rules for the former risk contract managed care program. Consequently, the sites had to adapt to changed rules when they were published.

Capacity and Enrollment

Sites vary significantly in (1) their capacity for caring for Medicare-eligible retirees, (2) how close enrollment is to capacity, and (3) what fraction of eligibles has enrolled. This variation suggests that potential demand for a subvention program is uncertain. Retirees' enrollment decisions reflect several factors—some, DOD may be able to influence; others, such as the extent of managed care presence in an area, are outside its control.

In establishing their enrollment capacity-which effectively became an enrollment target-some sites were more conservative than others. Sites' assessment of their resources focused on the availability of primary care managers—physicians and other clinicians who both provide primary care and serve as gatekeepers to specialist care. Additionally, the national TRICARE office developed a model to show how many enrollees a site would need to meet its level-of-effort threshold and start receiving increased resources from subvention, and these results were made available to sites. Capacity varied from San Antonio, Texas, the largest site with four hospitals and a capacity of 12,700, to Dover, Delaware, which provides only outpatient care in its military health facility and set its capacity at 1,500.

Many DOD officials and other observers expected that sites would be deluged with applications and would rapidly reach capacity, but this did not happen. One site has reached capacity, but only after several months. Other sites have enrolled between 46 percent and 92 percent of capacity as of the end of June 1999.

As table II.1 shows, there is a four-fold difference in sites' enrollment as a percentage of eligibles in their catchment areas-from 8 percent (San Diego, California) to 36 percent (Keesler, Mississippi). Several factors may explain this variation:

—Enrollment in other Medicare managed care plans varies widely, from one site with a low percentage of eligible enrollees (San Diego)—where nearly 50 percent of dual eligibles are in private Medicare managed care plans—to two sites with higher percentages of enrollees (Keesler and Dover)—where no one is in managed care because no plans are available.

—The availability of military care varies. Several sites emphasized in their marketing that retirees who did not enroll could not count on receiving space-available care. This information might spur retirees who prefer military care to enroll in Senior Prime. At other sites, space-available care was less of an issue. At these sites, prospective enrollees who believe that they can continue to receive space-available care may not see an advantage in enrollment but rather a disadvantage—especially because enrolling in Senior Prime locks them out of other Medicare-paid care.

—Sites may differ in the amount of space-available care they have given in the past and in beneficiaries' satisfaction with that care. These factors could also affect the decision to enroll.

—Some retirees expressed reluctance to enroll because the demonstration is due to end in December 2000. They also noted that they did not get information about how, after the demonstration ends, enrollees would transition back to space-available care, traditional fee-for-service Medicare, or a Medicare managed care organization.

Table II.1.—TRICARE Senior Prime Enrollment

Enrolled [1]	Capacity [2]	Enrolled as a percentage of capacity	Total eligible	Enrolled as a percentage of eligibility
Madigan Army Medical Center, Wash.: 3,313	3,300	100.4%	21,709	15.3%
San Antonio, Tex.: 11,638	12,700	91.6%	41,215	28.2%
Naval Medical Center, San Diego, Calif.: 2,879	4,000	72.0%	35,619	8.1%

Table II.1.—TRICARE Senior Prime Enrollment—Continued

Enrolled [1]	Capacity [2]	Enrolled as a percentage of capacity	Total eligible	Enrolled as a percentage of eligibility
Keesler Medical Center, Miss.:				
2,617	3,100	84.4%	7,361	35.6%
Colorado Springs, Colo.:				
2,823	3,200	88.2%	13,689	20.6%
Dover, Del.:				
685	1,500	45.7%	3,905	17.5%
Totals:				
23,955	27,800	86.2%	123,498	19.4%

Note: Status as of June 21, 1999.
[1] Includes only people who were 65 years old at the beginning of the demonstration.
[2] Capacity at the beginning of the demonstration. Does not include capacity for those who turned 65 after the demonstration started.

Managed Care Issues

The subvention demonstration for military retirees aged 65 and over is a new endeavor that highlights challenges for DOD to operate as a Medicare managed care organization. The first is operational—putting in place procedures, organization, and staff to deliver a managed care product to these seniors. The second is economic and organizational—creating the business culture that reconciles delivering services to this illness-prone population with cost-consciousness.

DOD's reliance on contractors (like Foundation Health and Humana) has enabled it to accomplish key managed care tasks. DOD overcame obstacles in launching TRICARE Senior Prime as a managed care organization. Specifically, to establish and run a managed care plan requires infrastructure-the ability to market the plan, enroll members, and recruit, manage, and pay a provider network. In building Senior Prime organizations at the six sites, DOD has benefited from its TRICARE Prime experience, and from its contractors who help with or perform many of these tasks.[15] Sites with well-established TRICARE Prime organizations that had worked with the same contractor for several years seemed to us to have a sizeable advantage in establishing Senior Prime. It is not yet known what effect DOD's extensive use of contractors will have on DOD costs for Senior Prime. But an expanded, permanent subvention program would require establishing and monitoring contractors at many new sites. That would make contractor quality, relationships, and costs a pivotal and uncertain feature of a potential DOD subvention program.

Payment Issues

DOD and HCFA have devised payment rules to meet the statutory requirement that Medicare should pay DOD only after its spending on retirees' care reaches predemonstration levels—that is, after it has met its baseline, or level of effort. These rules have added to the difficulty and the complexity of the demonstration. Furthermore, they have resulted in Medicare payments to DOD not being immediately distributed to the sites. As a result, DOD site managers tend to view DOD appropriations as the sole funding source for all Senior Prime care delivered at military health facilities; the managers are likely to consider Medicare subvention payments as irrelevant to their plans for dealing with capacity bottlenecks or other resource needs in TRICARE Senior Prime.

The demonstration's payment system requires extensive cost and workload data—data that are often problematic and difficult to retrieve and audit. It also involves a complicated sequence of triggers and adjustments for interim and final payments from Medicare to DOD.

Interim payments are made to DOD for care delivered at each site that is above a monthly level-of-effort threshold. A reconciliation after the end of the year to determine final Medicare payments can result in DOD returning a portion of those interim payments if the level of effort for all sites for the entire year is not reached. DOD would also return Medicare payments if data showed that the demonstration population was in better health than that allowed for in the Medicare payment

[15] The DOD sites relied on the TRICARE contractors for handling enrollment, claims processing, and network management. They have also, to varying degrees, assisted with the application, site visit, quality assurance, and utilization review areas.

rates, or if payments exceed the statutory cap ($50 million in the first year, $60 million in the second, and $65 million in the third).[16]

Because of the potential for adjustments after the close of the year, the payment rules create some uncertainty for DOD. DOD cannot be certain that it will retain all—or even part—of the monthly interim payments at the end of the year. DOD has been slow to distribute interim payments to the sites, in part because some of the money may have to be returned to HCFA. This creates great uncertainty for DOD sites and means that care under subvention is currently paid for with DOD's appropriated funds. The demonstration's payment method differs significantly from the Medicare managed care payment system, in which payments are made at the beginning of the month to cover care delivered during the month.

Based on experience to date with the demonstration, any payment approach for subvention must be even-handed (that is, it should favor neither HCFA nor DOD); straightforward and readily understandable; and prospective (DOD and its sites should receive payment in advance of delivering care to enrollees). The demonstration's payment mechanism, which relies on level of effort, is functional in the short term—although the calculation of level of effort has weaknesses.[17] However, this payment mechanism may not be appropriate over the longer term for an extended or expanded subvention program. Moreover, a credible long-term payment system should start with a zero-based budgeting approach: first, determining the cost to DOD of providing TRICARE Senior Prime care to dual eligibles and then deciding how much care will be provided from DOD's appropriations and how much from Medicare reimbursement.

Chairman THOMAS. Thank you, Doctor. When we were looking in the BBA 1997 legislation, at a subvention program, you are correct, DOD with Tricare seemed to be, interestingly enough, about a year or 18 months or 2 years ahead of the VA Vision Program.

You just testified that it looks as though it needs to have another year to 18 months in terms of maturity, but the VA—the DOD subvention program has been going for sometime now and they still have some inadequacies. How comfortable are we that there has been a understanding of the problems with DOD, principally on an accounting basis, which the VA would face as well, and VA's learning curve in terms of what it needs to show before they could have a similar subvention?

Mr. SCANLON. I think we have learned a lot from DOD in terms of the problems we face. We have not always mastered the solutions. In fact, in looking at level of effort in the reports that we have issued, one of the concerns is to ascertain more precisely what level of effort really is, it is impossible, given the data that were available and used by DOD at the time. And one of the potential options is to change the data that are used, to recalculate level of effort using more current data.

We also, I think, have to recognize some very significant differences between the VA system and the DOD system. While we have learned in principle the importance of data, and accurate data, to setting level of effort and to being able to manage the program, we are starting out with an entirely different environment in the VA in terms of the challenges or the barriers or the obstacles that are going to crop up as we try to actually implement subvention.

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[16] The enrollment targets for each site reflect the statutory caps. Consequently, rebates (from DOD to Medicare) as a result of payments exceeding the cap are unlikely.

[17] These issues were discussed more fully in *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustment and Raise Broader Concerns* (GAO/HEHS–99–39, May 29, 1999).

Chairman THOMAS. Did you look at any of the data, because a lot of times you have data, but you don't look at it from a particular conceptual approach? But, clearly, this joint use by people who are otherwise eligible for the VA system in using HMOs under a Medicare structure provides us perhaps with a case study in choice. Did you find anything that popped out at you as to why a Medicare-eligible veteran would use particular services from the VA, notwithstanding the fact that they were, perhaps, getting the bulk of their medical services from an HMO arrangement, so that we could begin to understand what it was that they thought the VA had as an advantage? Because, clearly, one of the main problems with the VA is that more and more people believe that it does not provide a profile of medical services that your typical—and especially if the VA Administration is focusing on a higher income, nonservice-related injury veteran—could provide.

Mr. SCANLON. Mr. Backhus may be able to answer that more from the work that they have done, but in terms of subvention itself, we are now looking at some of the views of persons that enrolled in the DOD demonstration and those who did not enroll, and we will be able to have some information on that point, but I think not in great detail.

We do know that for the general enrollee in a Medicare+Choice plan, there are times when they do seek services outside the plan because they may find the provider more convenient, or the plan—legitimately managing their care—may say, we do not want to provide you that service.

Now, in the case of a veteran who is able to get that service for free from the VA—as opposed to individuals who don't have an additional HMO benefit covering that service—it is another factor that may play into that decision to use the VA rather than the HMO.

Mr. BACKHUS. Mr. Chairman, you——

Chairman THOMAS. If you can go out of plan and it costs you nothing, that may be the ideal health plan.

Mr. BACKHUS. Mr. Chairman, we have not specifically looked at that particular issue; however, I do know that from having spoken with many different VA hospital officials as well as DOD hospital officials, the same thing happens there by the way. There are military retirees who are over 65 who have enrolled in and so forth, and so forth. In many cases, they do approach the Medicare Choice HMO first for care. They are referred. That's where the idea——

Chairman THOMAS. So, in part, it is either a cost shift, if you put it in a crass, commercial, economic way, or it is, if you don't like what we have to offer, this is an alternative available to you?

Mr. BACKHUS. Precisely.

Chairman THOMAS. The Senate added fee-for-service, which is not part of the DOD subvention. What is your attitude about their ability to deal with that issue, if in fact it is included, notwithstanding the adamant opposition by the Health Care Financing Administration to go to a fee-for-service beyond a capitated plan? Can it be done in the same timeframe?

Mr. BACKHUS. Well, I don't think it can, no.

Chairman THOMAS. OK. That is more than enough. Thank you.

Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. I am trying to read your reports, since we just kind of got it in our packages this morning. So I am trying to catch up with this.

But, particularly, I think on page 8 and 9, where you are kind of talking about in the future of VA benefits and what is going to happen, can you summarize that for me a little bit of what you see happening? I am kind of concerned when we are expanding and now we may be excluding and we might be, with the Priority 7 and the amount of resources that might be available. And maybe is some of it just due to the lack of what we put in our budget to take care of some of these issues as we do this?

Mr. BACKHUS. Surely. I could try to explain that. VA has the authority to enroll as many of the seven priority groups as they think they have the resources to provide care for. This current fiscal year, fiscal year 1999, VA made the decision that they could enroll and provide care to all veterans in all seven groups.

Therefore, that means that every veteran who wants to use the VA can enroll and begin immediately obtaining care. VA has to decide every year. There are significant concerns that the budget request for fiscal year 2000 does not contain sufficient money to enroll all seven priority groups for next year.

It is not clear at this time what that decision from VA is going to be, but the implications are that should the VA decided to enroll all seven priority groups and finds itself with insufficient money to provide care, then the quality of that care begins to suffer. Waiting times increase. Particular care won't be denied but when veterans inquire and try to seek an appointment, rather than perhaps getting something in 30 days it might be 50, 60, 70.

There are indications this year, at this time, and in some places, veterans are already waiting half a year to get an appointment. The crunch for the moment seems to be in primary care. We all know that there is plenty of inpatient capacity because these buildings are big and were built many years ago and it doesn't——

Mrs. THURMAN. Would you say that every place, or are there some geographic areas where that may not be true?

Mr. BACKHUS. It is clearly varied. Some places are much better than others, much more capable than others. There's a capacity——

Mrs. THURMAN. Just because of the demographic changes within a State?

Mr. BACKHUS. That is what has happened. Historical funding has pretty much remained constant, yet the veterans, as you know, have moved to around the sunbelt, and that resource shift hasn't caught up. And the budget has been flat-lined for the last several years.

Mrs. THURMAN. The budget issue is one that—when you did and looked at this, particularly from the expansion of services to all veterans, and then looking at it from the subvention, but, just as importantly, as we have expanded into the free-standing clinics, has that helped reduce some of this waiting or is that potentially something that could be helpful if there were more of those?

Mr. BACKHUS. Those are obviously primary care.

Mrs. THURMAN. Correct. And you had said those were one of the larger areas we are having——

Mr. BACKHUS. That has increased access tremendously for veterans. It has made the health care closer to where they live. And it has obviously increased the capacity. It has had a significant effect on VA's ability to meet that primary care demand. However, that money has to come from somewhere, and at the present time we estimate that one in every four dollars, VA health care dollars, is spent maintaining these large, huge medical facilities that are, in many cases, more than half empty.

Mrs. THURMAN. But would you consider these then in that context somewhat cost effective for delivery of service?

Mr. BACKHUS. Absolutely they are. They appear to be.

Mrs. THURMAN. Thank you.

Chairman THOMAS. Thank you very much. One of the difficulties, of course, is that the VA runs a hospital system, but hospital folks sometimes are not the people making decisions in terms of how resources are used. And of course one of the problems is that Congress oftentimes intervenes.

One of the difficulties is that now that the Senate has placed a fee-for-service aspect in what had been a broad-based attempt to assist and accommodate, you might look to the fact that not all VA hospitals are capable of offering a primary care, broad-based health package, and that if there are hospitals that are specialty hospitals, they would not be able to function in the capacity that a capitated plan would envision them to participate.

And so, I believe there is a degree of motivation in including a fee-for-service plan to preserve hospitals that otherwise probably should not continue to be open if in fact the primary purpose of the Veterans Administration is to provide service to veterans who can otherwise not get health care service. That clearly has not been the direction.

The Chair was wrapping up. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. No, thank you. I will review your testimony, though, because it is a subject I am interested in—just unfortunate that there is no time my schedule for it.

Chairman THOMAS. That is true, and frankly, this is not the first time we have visited the subject. It is probably not going to be the last.

We are very dependent upon your analysis of whether or not these departments dealing with billions of dollars can, in fact, provide an accounting for the money that they spend. That is the key as to whether or not dollars shifted from the Medicare Program into either the Department of Defense or Veterans Affairs can have an assurance that it is being used for the purpose for which we would be providing it.

And I would continue to rely on you, primarily, the Congressional Budget Office, but also the General Accounting Office to answer the question, if in fact, this is going to save money, how come we have to keep putting money up to pay for a program that clearly the accounting folks tell us will cost money?

Thank you very much for your testimony. And the Subcommittee stands adjourned.

[Whereupon, at 12:24 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Benjamin H. Butler, National Association for Uniformed Services, Springfield, VA

Mr. Chairman, The National Association For Uniformed Services (NAUS) appreciates the opportunity to present this statement concerning Medicare "VA Subvention."

The National Association for Uniformed Services represents all ranks, branches and components of uniformed services personnel, their spouses and survivors. Our nationwide association includes all personnel of the active, retired, reserve and National Guard, disabled and other veterans of the seven uniformed services: Army, Marines, Navy, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.

The overall purpose of NAUS is to support legislation which will uphold the security of the United States, sustain the morale of the Armed Forces, and provide fair and equitable consideration for all members of the uniformed services.

MEDICARE REIMBURSEMENT

The National Association for Uniformed Services supports legislation to authorize Medicare reimbursement for heath care services provided to Medicare-eligible veterans in facilities of the Department of Veterans Affairs. Senator Jeffords has already introduced S. 445, which would require a VA Medicare Reimbursement Demonstration at 10 geographically disperse sites. We would like to see full Medicare reimbursement legislation passed promptly for both VA and DoD. If that cannot be done we would support a demonstration project. However, the longer we delay full implementation the greater the injustice to military retirees and eligible veterans.

We are gratified that there is a growing understanding that offering discretionary veterans an opportunity to use Medicare to reimburse their VA care creates additional access and can actually save Federal tax dollars. NAUS believes this is a common sense proposal and deserves immediate enactment. It is consistent with efforts to streamline and share Federal resources, it is politically feasible, and is an excellent way of identifying savings for the Medicare Trust Fund. Study after study has shown that military and VA medical facilities provide significant savings over commercial medical providers which the veterans would otherwise use.

Some features which we recommend be incorporated into VA Medicare reimbursement include:

Demonstration Phase. Authority to expand the test after each 6 month period should be incorporated into the bill. The Department of Veterans Affairs Statistical Brief, Projections of the US Veteran Population: 1990 to 2010, states that an estimated 500,000 veterans die in the United States each year. Deaths of U. S. World War II veterans presently account for almost 3 of every 4 veteran deaths and are projected to peak at 380,000 in 2001. A three year demonstration, then a lengthy review, could result in a delay of up to five years or more before a nationwide Medicare reimbursement program is in place. That is too late for these older veterans. They need help now. As quickly as cost savings are determined, the program should be expanded.

Cost Sharing. We strongly recommend that cost sharing be waived for retired veterans. These veterans who served to retirement, many through 3 wars and the 45 year Cold War, were promised free lifetime medical care in exchange for a lifetime of service (See Exhibit B). With the closure of over 58 military hospitals, downsized clinics, a chronically underfunded Defense Health Program, and cutbacks in personnel, hundreds of thousands of retired veterans have been abandoned by their employer, the Department of Defense. These veterans are the only federal retirees who lose their guarantee of employer provided health care at age 65. Many of these veterans have purchased "Medigap" policies. The VA has the authority to bill these policies and we do not object to that. However, to require this category of veteran to cost-share is wrong and should not be done. If the retired veteran has a "Medigap" or other policy, continue the current practice of 3rd party collections; but if he does not have a policy, then the only party billed should be Medicare, not the retired veteran.

THIRD PARTY COLLECTIONS

We strongly support a bill to revise the authorities relating to third party collections. We support allowing the DVA to keep the amounts collected for services provided by DVA medical facilities. Collections should be made at the level closest to the point of service for which the charge is made and the funds collected, in general, should remain there. This would provide an incentive to the facilities to provide service, attract patients and to collect for their services. The free enterprise system

has been proven to be the most efficient means of allocating goods and services, certainly far more efficient than top down command economics. Collecting funds at, or close to, the point of service and leaving most of them there to help fund these services, would energize local DVA medical facilities, reward efficiency and performance, provide incentives that mirror the best results of free enterprise and greatly increase the efficiency of and patient satisfaction with the DVA hospital system and reduce administrative costs. *The provisions in the draft bill to exclude these funds from any OMB estimates relative to required appropriations is absolutely essential, should be rigidly enforced, and requires constant vigilance.*

Finally, the National Association for Uniformed Services thanks this committee for its support of Medicare reimbursement, for holding this hearing and its interest and concern for our service members, their families and survivors. Mr. Chairman thank you again for giving us the opportunity to present this testimony today. I will be happy to answer any questions you have.

Statement of Paralyzed Veterans of America

Chairman Thomas, Ranking Minority Member Stark, members of the Subcommittee, the Paralyzed Veterans of America (PVA) appreciates this opportunity to testify, for the record, concerning the participation of the Department of Veterans Affairs (VA) in a Medicare subvention pilot program in cooperation with the Health Care Financing Administration of the Department of Health and Human Services.

PVA is a congressionally chartered veterans service organization, representing over 18,000 members with spinal cord injury or dysfunction, whose mission is to be the leading advocate for quality health care for our members; promote research and education addressing spinal cord injury and dysfunction; ensure the availability of benefits earned through honorable military service; and to maximize the civil rights, opportunities, and independence of our members. As a veterans advocacy group, PVA stands ready to support the veteran community of more than 25 million men and women to ensure that each eligible veteran, and his or her dependents, receive the benefits earned through service to this country.

Our testimony today is an attempt to reflect PVA's broader role and interest in preserving quality VA health care, not only for the veterans who are statutorily eligible for services, but also for the more than 4 million disenfranchised Medicare-eligible veterans aged 65 and over, who, because of the limited Medical Care Appropriation and their higher income level, are not eligible to receive health care services from the VA.

The delivery of health care has changed dramatically over the last five years. The intense pressure to control costs, coupled with the rapid spread of managed care, has had an impact on every health delivery system in this country, including VA. As a hospital-based system with an aging infrastructure and patient population, the VA has not faired well under the constraints of a global budget capped by the limitations of the Balanced Budget Act of 1997. Meanwhile, the rapidly changing health care landscape of the last few years has made management of VA health care extremely challenging. Its leadership has worked tirelessly, if not always successfully, to move the delivery of health care away from an institutionally-based medical model to a more streamlined ambulatory care system. The greatest stumbling block to completion of this necessary revampment has been adequate resources. It should be noted that change, especially dramatic change such as system transformation, does not come without costs and committed investment. VA, unlike the private sector, cannot issue securities, borrow funds, or merge with other systems to find needed capital to finance what it needs to become to adequately serve and attract new veteran workload. It must rely on prudent management and legislative fixes.

The VA, in P.L. 105–33, the Balanced Budget Act of 1997, was granted the authority to retain collections from third-party payers. Although VA collection efforts have met with mixed success, this legislation has forced VA away from the outdated practice of averaging costs to the development of reasonable charges for services rendered to veterans—a universal billing practice demanded by all insurers and health plans. It is our understanding that VA will implement its reasonable charges billing system on September 1, 1999.

VA has more than ten years of experience with shared services and has worked in partnership with the Department of Defense (DoD) and with local communities nationwide on a multitude of contractual arrangements for shared services. Monies obtained from sharing agreements have been used to augment and enhance services for veterans, while providing cost-effective care for DoD beneficiaries. Community arrangements have also created numerous opportunities to control costs through the

shared purchase of expensive medical equipment and the development of other shared service arrangements. P.L. 105–33 enhanced VA's sharing authority. Together, these programs have laid the groundwork for VA's potential participation in Medicare subvention—an important aspect of VA's long term strategy to maintain a comprehensive and high quality health care system.

Given that managed care is now a permanent and growing part of the health delivery landscape, it is essential that VA be able to play in that marketplace. Speaking for PVA and others in the veteran community, there is qualified support for VA's participation in the Medicare Subvention pilot. An important term of participation is that Medicare-eligible veterans must be offered the same participation opportunities as other Medicare beneficiaries, especially, the option to choose to come to the VA under a fee-for-service Medicare pilot, as well as the managed care pilot.

Previous attempts to legislate VA Medicare subvention have included a fee-for-service component. It is fitting that present efforts also include this important provision. Medicare-eligible veterans who are not currently receiving services in the VA must be allowed the opportunity to overcome past VA disenfranchisement by participating on an equal footing with current Medicare beneficiaries, choosing either managed care or continued participation in a fee-for-service arrangement. Currently, the Medicare program allows beneficiaries the freedom to choose their service arrangement. Veterans must be permitted the same choice options. Just as current users of VA health care bring their third-party reimbursement to the VA, Medicare-eligible veterans should be allowed to freely participate in the Medicare program, which they paid into throughout their years of employment.

PVA appreciates the constraints and potential problems that VA would face under a fee-for-service Medicare pilot option. However, it is the position of this organization that these barriers to participation are no greater and, in fact, are very similar to those posed under a managed care option.

The inclusion of a fee-for-service option, would, as previously stated, offer choice and equal participation for a universe of more than 4 million Medicare-eligible veterans who have been disenfranchised from the VA solely by their income and the inadequacy of VA appropriations. In addition, the fee-for-service option would also enable VA to develop comparative data on the two options.

For either or both options to function successfully, Congress must require VA to institute data systems to track the costs and services provided to each eligible participant. This type of accounting is the accepted standard for successful health plans; no less should be expected of the VA. One of VA's greatest failings has been its inability to develop accurate cost data. This problem has been historically evidenced in its Medical Care Cost Recovery Program. VA's system of averaging costs has frustrated not only insurers and health plans, but has, in some cases, discouraged eligible veterans from using the system. Fear of being billed for non-service connected care, which is routinely covered in the community setting, is a strong deterrent to a veteran living on a fixed income.

We view the current DoD TRICARE Senior Prime program as a first step in the realization of VA's potential successful partnerships. VA participation in Medicare subvention appears to be the next logical step in the provision of comprehensive, seamless care to veterans.

We understand that VA is very eager to be part of a Medicare subvention pilot and is willing to participate in a managed care subvention no matter what the initial cost to the Department. It is for this very reason that we feel a fee-for-service component should be added to the pilot. Understanding that the operation of the pilot must be cost-neutral to the Medicare Trust Fund, VA would be compelled to demonstrate that it can market, track, and operate a high quality system that will attract new users over its current level of effort. Recent articles on Medicare+Choice point to an undercurrent of dissatisfaction among providers and consumers in managed care communities. A VA fee-for-service model will allow for a useful comparison of what veteran consumers want and will use.

We recognize that at the end of the three-year pilot the Health Care Financing Administration, VA, or both could view this effort as not worth sustaining. We urge this Committee to approve a VA Medicare Subvention program, and to make certain that this program includes a fee-for-service component.

Statement of Mark H. Olanoff, Retired Enlisted Association, Alexandria, VA

Mr. Chairman, Mr. Ranking Member, distinguished subcommittee members, the 100,000 members and auxiliary of The Retired Enlisted Association (TREA) appreciate the opportunity to present to you the views of the association regarding the proposed Medicare Subvention demonstration program to take place at Department of Veterans Affairs health care facilities.

TREA has long supported the proposal which would allow the Department of Veterans Affairs to be reimbursed by the Health Care Financing Administration (HCFA) for treating Medicare-eligible veterans. In fact, this program was listed as TREA's number one veterans benefit priority before a joint session of the Veterans Affairs Committee.

Commonly referred to as Medicare Subvention, this particular program can accomplish two goals: one, the VA would benefit by being reimbursed by Medicare for providing care to veterans who may have received their care elsewhere. Two, it greatly improves veterans' access to health care. Presently, many older veterans are severely limited in their health care options. In particular, military retirees over the age of 65 are forced out of the TRICARE system. These retirees were the ones who were promised free life-time health care if they served twenty or more years in the military. Servicemembers were not told that legislation passed in 1956 and 1966 effectively eliminated that benefit. In fact, recruits up until 1993 were being told of the promise of free medical care in return for a military career. However, no reference is made to the reality of base closure and hospital down-sizing and the impact on retiree health care such events have. Allowing those veterans to receive their health care at the VA will greatly expand the number of facilities a military retiree could turn to for care, thereby greatly improving the health care benefit offered to those who have served this nation.

TREA is aware of the discussions regarding this proposed demonstration and whether or not it should be an HMO-style or Fee-for-Service style program. The members of this organization urge the members of this Committee, and their colleagues in the Senate, to pass this test in either form. While this debate goes on, veterans continue to lose health care options. Congress needs to act to protect veterans. TREA also urges this committee to adopt the position of their colleagues in the Senate which would allow for a three year demonstration to be preceded by a one year period for administrative set-up. The experiences of the Department of Defense regarding the establishment of their demonstration program should be heeded to ensure that the VA's program runs smoothly. Hospital certification alone consumed nearly one year of the DoD program. It is important that lesson be used to provide Medicare-eligible veterans with this benefit as quickly as possible.

By establishing this program, in conjunction with the Veterans Millennium Health Care Act, those who served honorably in our nation's armed forces can be assured that quality health care will be available throughout their life. The emergency care, long-term care, eligibility reform and VA Subvention proposals will enable TREA, and other veterans service organizations, to encourage our members to receive their health care through the Department of Veterans Affairs. For too long the VA has only offered a partial benefit, discretionary long-term care, no emergency care program, space available care. The proposals before Congress at this time guarantee that the VA will offer veterans a complete package and VA Subvention is, and will remain, a critical part of that.

Statement of Robert F. Norton, Retired Officers Association, Alexandria, VA

INTRODUCTION

The Retired Officers Association (TROA) is pleased to submit this statement to the Subcommittee on Health of the House Ways and Means Committee on Medicare Subvention for the Department of Veterans Affairs.

TROA is the fourth largest military veterans organization with nearly 400,000 members. Our membership consists of veterans and survivors who are retired officers, active duty and National Guard / reserve officers of the seven uniformed services and their surviving spouses. Collectively, there are 1.67 million military retired veterans who are eligible to use VA health care either as "mandatory" or "discretionary" veterans.

As a founding member of The Military Coalition (TMC), TROA works closely with the 29 other veterans and military organizations in The Coalition. TMC represents

the collective interests of over 5 million current and former members of the seven uniformed services, plus their families and survivors. TMC's Committee structure includes a Veterans' Committee which works veterans issues for The Coalition. This Statement, however, represents the views of TROA alone. TROA does not receive any grants or contracts from the federal government.

Background

VA Subvention would permit Medicare funds to be used for Medicare-sponsored services to eligible veterans in VA facilities. *VA Subvention continues to be TROA's highest veterans' health care legislative priority.*

The majority of stakeholders, including TROA, the other 29 members of The Military Coalition, most veterans service organizations (VSOs), and the Department of Veterans Affairs (DVA), agree in principle on the need to test using Medicare funds for the non-service connected care of older veterans. The problem appears to be in the design of the test and related cost issues.

Late in the last session of Congress, the Chairmen of the House Veterans Affairs Committee (HVAC) and the Subcommittee on Health of the House Ways and Means Committee reached an agreement to test subvention and to create a new program for certain veterans living in remote-areas. Under the "remote access" program, the VA would enter into agreements with health care maintenance organizations (HMOs) and other providers to provide care for Medicare-eligible veterans with a service-connected disability, injury, or illness. Medicare would reimburse the providers for the non-service-connected care and the VA would reimburse the providers for service-connected care. The new program would run for three years and, if successful, would be extended or made permanent. The House passed the "enhanced" VA subvention bill but no action was taken on a Senate subvention proposal sponsored by Senators Rockefeller and Jeffords. The Senate bill would have authorized a subvention test but not a "remote access" program for disabled veterans as in the House bill. In the current session (106th Congress) a VA Subvention test has been endorsed this session by key Senate Committees.

The Senate Finance Committee approved a test of subvention at eight VA hospitals, to be selected jointly by the Secretary of Veterans Affairs and the Secretary of Health and Human Services. TROA is pleased to note that the Senate proposal envisions testing subvention on a fee-for-service basis as well as the managed-care concept. Under the latter, retirees would have to enroll and agree to get all their care through the VA (VA would contract for care it couldn't provide in-house). Under the fee-for-service concept, the VA would be partially reimbursed for providing retirees care on a visit-by-visit basis, without requiring retirees to enroll. The Senate Finance Committee proposal envisions a four-site test of each concept.

Each test allows the VA and Medicare up to one year for administrative setup, followed by three years of care delivery. The managed care program would start during calendar year 2000, and the fee-for-service test during 2001.

The Need for VA Subvention

The fundamental issue regarding subvention is whether older non-disabled veterans who are already eligible for Medicare should be allowed to receive Medicare-sponsored services for non-service connected care in a VA facility.

Today, many Medicare-eligible veterans use VA health care for some services and a Medicare HMO for the rest of their care. The result is inefficiency, duplication of effort, and inconsistency in providing health care to these veterans. As a growing trend, this practice may not be in the best interests either of Medicare-eligible veterans or of the government. A recent VA study revealed that the number of "dual-eligible" veterans—those who receive care from the VA and care from a Medicare HMO is "increasing rapidly" and correlates with national Medicare HMO enrollment rates in general—18%. The study showed that:

- VA patients covered by Medicare-HMOs already receive substantial amounts of VA care.
- Estimated Medicare payments to Medicare HMOs on behalf of "dual-eligible" veteran patients were $305 million in one year (FY 1996).
- For veterans covered by Medicare HMOs for a one-year period (FY 1996), VA spending on Medicare services to those same veterans was $146 million.

Medicare HMO enrollment trends reveal an interesting pattern when compared to the VA's funding model, known as VERA (the Veterans Equitable Resource Allocation). VERA is re-directing VA resources away from parts of the country where Medicare HMO enrollments are rising significantly. In the Northeast region, for example, the proportion of Medicare eligible VA patients enrolled in Medicare HMOs

is up substantially: Massachusetts—3.0% to 12.2%; New York—4.1% to 4.9%; New Jersey—0.6% to 8.3%; Pennsylvania—2.3% to 13.2%.

VERA distributions of VA funds, however, are down significantly in the corresponding VA service regions (VISNs) as shown below:

VA Funding Trends in Certain Regions According to 'VERA' (FY 1996—1999)

- Boston (VISN 1)—8.0%
- Albany (VISN 2)—5.8%;
- Bronx (VISN 3)—6.9%;
- Pittsburgh (VISN 4)—2.0%;
- Baltimore (VISN 5)—11.0%.

If Medicare funds were allowed to be used in VA facilities, the VA could provide health care directly to those who increasingly are turning to Medicare HMOs for care especially in parts of the country where VA capacity and resources ae being cut back. Whether veterans would choose VA care over their Medicare HMOs should be a research question from a VA subvention test. As important, a test could determine whether Medicare services can be offered at less cost in a VA setting.

A VA Subvention test would also be useful in parts of the country where veteran enrollments and VERA distributions are on the rise. That's because Medicare funds could be used in a VA setting to pay for the care of the increasing numbers of older veterans eligible for Medicare. The study noted above showed that the proportion of Medicare eligible VA patients who are also enrolled in Medicare HMOs is significant in those areas where VERA distributions are increasing. The following table illustrates this:

Percent Medicare-Eligible Veteran Patients Also Enrolled in Medicare HMO

State	% VA Patients Also Enrolled in Medicare HMOs	VISN LOCATION	VERA INCREASES FY 96–99
Arizona	30.5	Phoenix	+16.8%
California	34.7	San Francisco	+8.8%
		Long Beach	+4.0%
Nevada	24.8	(3 VISNs overlap).	
Florida	20.7	Bay Pines	+16.1%

(Note: VISN areas of responsibility do not correspond with State boundaries). Texas, Washington, Colorado, and Louisiana also have experienced significant growth in the number of VA patients enrolled in Medicare HMOs and VERA increases to the corresponding networks.

Authority to test VA Subvention would allow the VA and Medicare to evaluate whether Medicare funds could be used more efficiently in VA facilities where Medicare-eligible enrollments are increasing.

The Retired Officers Association fully supports the concept of VA Subvention and we urge the Subcommittee and the full House Ways and Means Committee to approve the parameters for a VA Subvention demonstration as soon as possible.

CONCLUSION

The Retired Officers Association deeply appreciates the work of the Chairman and the distinguished members of the Subcommittee on behalf of America's veterans including military retirees. They deserve assured and reliable access to Medicare services in VA facilities when they become eligible for Medicare.

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